Rocky Mountain Medical Journal

Minutes
Colorado and Utah
Meetings

Vol. 52—No. 11
35c Per Copy
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COLORADO PRESIDENTIAL ADDRESS—HEARING PROBLEMS
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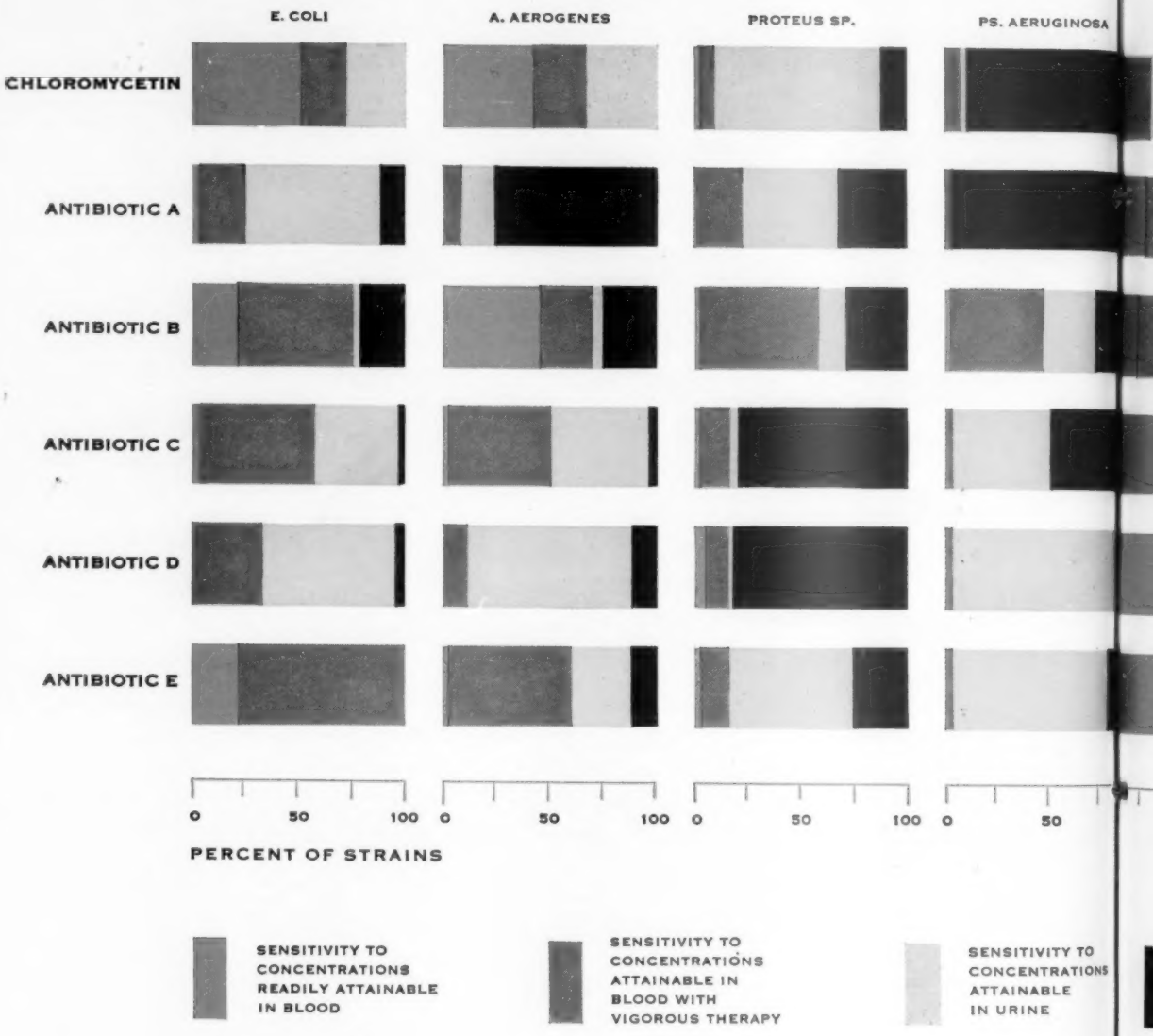
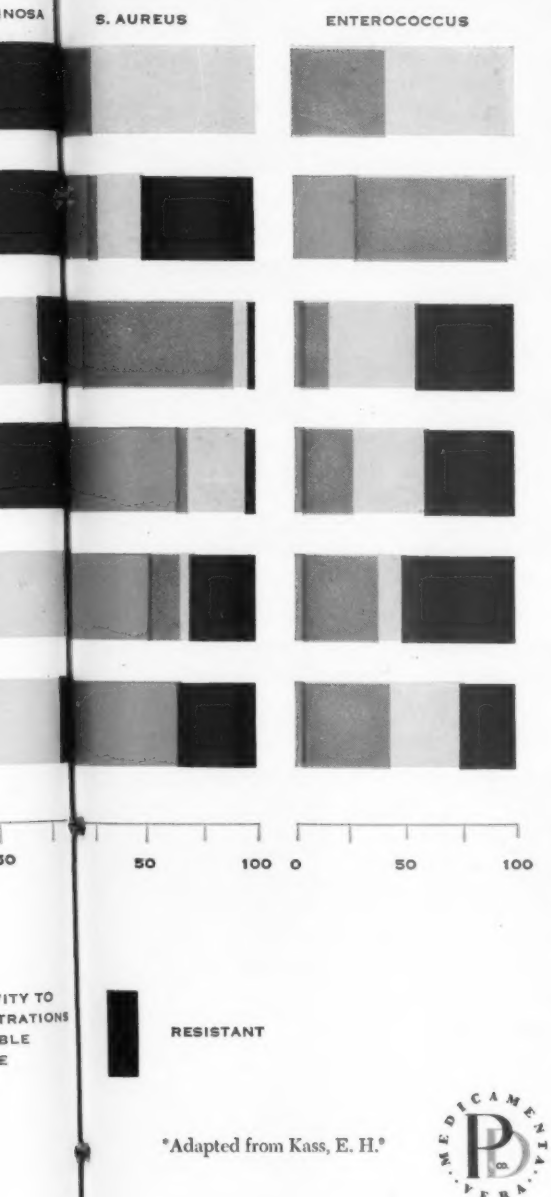


less resistance encountered...



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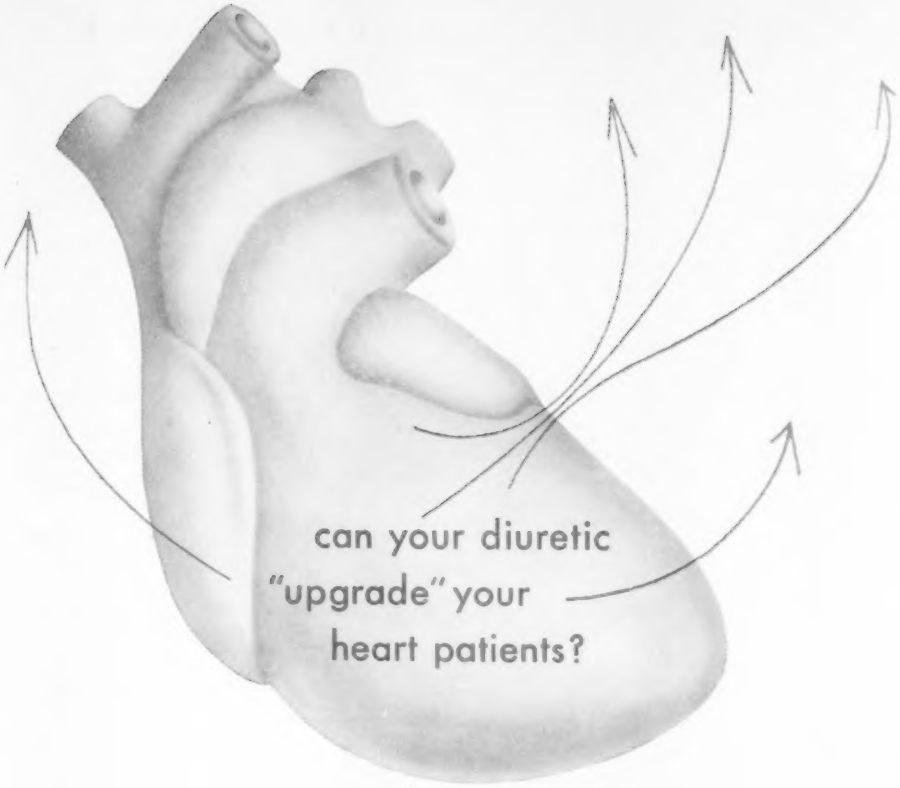

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Ownership and Sponsorship: The Rocky Mountain Medical Journal is owned by the Colorado State Medical Society and is published monthly as a nonprofit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado State Medical Society, assisted by an Editorial Board representing the sponsoring organizations. It is the Official Journal of the Colorado State Medical Society, the Montana Medical Association, the New Mexico Medical Society, the Utah State Medical Association, the Wyoming State Medical Society, the Rocky Mountain Medical Conference, and the Colorado Hospital Association.

Manuscripts: Scientific Articles, Case Reports, etc., from any state for which this is the Official Journal should be submitted to the Scientific Editor for that state as named in the Editorial Board, above. Other material from any participating state should be submitted to the Associate Editor for that state as named above. Manuscripts from outside the Rocky Mountain area should be sent direct to the Journal office. Manuscripts must be typewritten, double or triple spaced, using only one side of each sheet. It is the policy of this Journal to omit bibliographies.

Advertising: National representatives: The State Journal Advertising Bureau, 535 North Dearborn Street, Chicago 10, Ill. Local advertising from firms in the Rocky Mountain area should be submitted to the Associate Editor of the appropriate state or to the Journal office. Advertising forms close on the 15th of the month preceding publication; allow ten days additional to insure submitting proofs for approval.

Subscription: $3.50 per year in advance, postpaid in the United States and its possessions; single copy 35c plus postage. Subscription is included in medical society dues of sponsoring state medical organizations.

Second Class Matter: Entered as second class matter Jan. 22, 1906, at the Post Office at Denver, Colo., under the Act of Congress of March 3, 1879. Accepted for mailing at special rates of postage provided for in Section 1103, Act of Oct. 3, 1917; authorized July 17, 1918.

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NEXT ANNUAL SESSION: SEPTEMBER 5-8, 1956; STANLEY HOTEL, ESTES PARK

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(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. 1:168, 1955. (3) Holbrook, W. P.: M. Clin. North America 39:405, 1955.

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Legislative and Public Policy Committee: R. C. Derbyshire, Chairman, Santa Fe; M. H. Bartlett, Alamogordo; L. M. Pavletich, Raton; J. A. Dillahunt, Albuquerque; Junius Evans, Las Vegas; L. Hamilton, Artesia; Thomas Hoover, Tucumcari; Louis Levin, Belen; Allan Haynes, Clovis; R. H. Pousma, Gallup; Demarius Badger, Hobbs; Bill Marbury, Farmington; Pierre Salmon, Roswell; Renaldo Deveaux, Taos; W. D. Sedgwick, Las Cruces; P. A. Feil, Deming; W. L. Minear, Truth or Consequences; Sidney Baker, Silver City; P. L. Shultz, Los Alamos.

Advisory Committee to State Welfare Department: Marcus Smith, Chairman, Santa Fe; A. S. Lathrop, Santa Fe; Dan Cahoon, Roswell; Aaron Margulis, Santa Fe; Lewis Overton, Albuquerque.

Advisory Committee to State Health Department: Stuart W. Adler, Chairman, Albuquerque; Guy Rader, Albuquerque; Roy Goddard, Albuquerque; Frank W. Parker, Gallup.

Professional Insurance Committee: Omar Legant, Chairman, Albuquerque; Lewis Overton, Albuquerque; John S. Moore, Roswell.

Advisory Committee to Selective Service: H. L. January, Chairman, Albuquerque; C. P. Bunch, Artesia; Raymond Young, Santa Fe.

American Medical Education Foundation: E. W. Lander, Chairman, Roswell.

Rocky Mountain Medical Conference: H. L. January, Chairman, Albuquerque; Allen Service, Roswell; Victor Berchtold, Santa Fe; Lee Harris, Las Cruces; Charles Beeson, Albuquerque.

Governor's Committee for the Physically Handicapped: Eric Hausner, Chairman, Santa Fe; Lewis Overton, Albuquerque; J. A. Dillahunt, Albuquerque; Oscar Syme, Albuquerque.

Infancy and Maternal Mortality Committee: A. R. Pruit, Chairman, Roswell; Sophie Aberle, Albuquerque; Alvina Looram, Santa Fe; Martha Howe, Ranchos de Taos; R. H. Pousma, Gallup; R. V. Seligman, Albuquerque; L. F. Kuehn, Albuquerque; Jack Hargan, Carlsbad; V. K. Adams, Raton.

Liaison Committee to Hospital Association: Lewis M. Overton, Chairman, Albuquerque; W. D. Dabbs, Clovis; H. W. Hodde, Hobbs.

THE UTAH STATE MEDICAL ASSOCIATION

OFFICER, 1955-1956

President: R. O. Porter, Logan.

President-Elect: James Z. Davis, Salt Lake.

Past-President: Charles Ruggeri, Jr., Salt Lake.

Honorary President: John Z. Brown, Sr., Salt Lake.

Secretary: Donald M. Moore, Ogden.

Executive Secretary: Mr. Harold Bowman, Salt Lake.

Treasurer: Alan P. Macfarlane, Salt Lake.

Councilor, Box Elder Medical Society: James H. Rasmussen, Brigham City.

Councilor, Cache Valley Medical Society: S. M. Budge, Logan.

Councilor, Carbon County Medical Society: L. H. Merrill, Hiawatha.

Councilor, Central Utah Medical Society: John B. Cluff, Richfield.

Councilor, Salt Lake County Medical Society: James F. Orme, Salt Lake.

Councilor, Southern Utah Medical Society: R. G. Williams, Cedar City.

Councilor, Uintah Basin Medical Society: T. B. Seager, Vernal.

Councilor, Utah County Medical Society: R. E. Jorgensen, Provo.

Councilor, Weber County Medical Society: Rich Johnston, Ogden.

Delegate to A.M.A., 1955-1957: George M. Fister, Ogden.

Alternate Delegate to A.M.A., 1955-1956: Eliot Snow, Salt Lake.

Editor of the Utah Section of the Rocky Mountain Medical Journal, 1957: R. P. Middleton, Salt Lake.

STANDING COMMITTEES

Executive Committee: R. O. Porter, Chairman, Logan; Charles Ruggeri, Jr., Salt Lake; James Z. Davis, Salt Lake; Donald M. Moore, Ogden; Alan P. Macfarlane, Salt Lake.

Medical Society, Salt Lake, Chairman; G. S. Rees, 1955, Central Utah Medical Society, Gunnison; John H. Rupper, 1955, Utah County Medical Society, Provo; Ralph C. Ellis, 1955, Weber County Medical Society, Ogden; Omar S. Budge, 1956, Cache Valley Medical Society, Logan; Dean C. Evans, S. Budge, 1956, Cache Valley Medical Society, Logan; Dean C. Evans, 1956, Southern Utah Medical Society, Fillmore; J. Eldon Dorman, 1956, Carbon County Medical Society, Price; Ray E. Spendlove, 1956, Uintah Basin Medical Society, Vernal; J. Gordon Felt, 1957, Box Elder Medical Society, Brigham City.

Rocky Mountain Medical Conference Continuing Committee: Heber C. Hancock, 1956, Ogden, Chairman; Emil G. Holmstrom, 1957, Salt Lake; Robert G. Snow, 1958, Salt Lake; R. P. Middleton, 1959, Salt Lake; Jesse J. Weight, 1960, Provo.

Scientific Program Committee: Donald M. Moore, Chairman, Ogden; R. P. Middleton, Salt Lake; L. Paul Rasmussen, Salt Lake; J. Poulsen Hunter, Salt Lake; Milo C. Moody, Spanish Fork; Philip B. Price, Salt Lake.

Medical Legal Committee: Paul K. Edmunds, Chairman, 1956, Cedar City; Oscar E. Grua, 1956, Ogden; H. R. Reichman, 1957, Salt Lake; Paul S. Richards, 1957, Salt Lake; Wallace S. Brooke, 1957, Salt Lake; Paul A. Pemberton, 1957, Salt Lake; A. J. Mohr, 1958, Tremonton; Wm. M. Nebeker, 1958, Salt Lake; G. S. Francis, 1958, Wellsville; Donald V. Poppen, 1958, Provo.

Medical Education and Hospitals Committee: E. D. Zeman, Chairman, 1956, Ogden; W. J. Reichman, 1956, St. George; Orson B. Spencer, 1956, Price; E. G. Holmstrom, 1957, Salt Lake; John A. Gubler, 1957, Salt Lake; John Z. Brown, Jr., 1958, Salt Lake; J. Russell Smith, 1958, Provo; Merrill C. Daines, 1958, Logan; U. R. Bryner, 1959, Salt Lake; G. C. Ficklin, 1959, Tremonton; W. R. Worley, Jr., 1959, Richfield.

Medical Economics Committee: Milo C. Moody, 1956, Spanish Fork; Gail W. Haut, 1956, Price; James A. Cleary, Chairman, 1957, Salt Lake; Philip M. Howard, 1957, Salt Lake; Russell N. Hirst, 1957, Ogden.

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General Committee on Public Health: John H. Clark, Chairman, Salt Lake; A. M. Okelberry, Salt Lake; Jay P. Bartlett, Ogden; Preston R. Cutler, Salt Lake; R. W. Farnsworth, Cedar City; Cloyd C. Hofheins, Bountiful; Leonard H. Taboroff, Salt Lake; B. M. Muirhead, Salt Lake.

Trauma Committee: A. M. Okelberry, Chairman, Salt Lake; Louis S. Peery, Ogden; John M. Bowen, Provo.

Cancer Committee: John H. Clark, Chairman, Salt Lake; Henry P. Plenk, Salt Lake; John H. Carlquist, Salt Lake; Warren B. West, Ogden; Richard A. Call, Provo.

Sewage, Water and Air Pollution Committee: Jay P. Bartlett, Chairman, Ogden; Glen R. Leymaster, Salt Lake; Glen C. Krebs, Provo; Boyd J. Larson, Lehi; M. Reed Merrill, Brigham City; A. James Fillmore, Logan; B. Kent Wilson, Price; K. B. Castleton, Salt Lake.

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Rural Health Committee: R. W. Farnsworth, Chairman, Cedar City; J. Howard Rasmussen, Brigham City; Paul G. Stringham, Roosevelt; Milo C. Moody, Spanish Fork; Kurt L. Jenkins, Marysvale; Thos. M. Hall, Payson.

(Continued on Page 948)

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THE UTAH STATE MEDICAL ASSOCIATION

(Continued From Page 946)

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Mental Health Committee: Leonard H. Taboroff, Chairman, Salt Lake; J. E. Trowbridge, Bountiful; Thurston D. Rivers, Ogden; Eugene L. Wiemers, Provo; L. G. Moench, Salt Lake; Joseph P. Kesler, Salt Lake.

Industrial Health Committee: R. M. Muirhead, Chairman, Salt Lake; Frank J. Winget, Salt Lake; E. M. Kilpatrick, Salt Lake; J. Russell Smith, Provo; Rulon F. Howe, Ogden; Paul A. Clayton, Salt Lake; Drew M. Peterson, Ogden; Paul S. Richards, Salt Lake; James Z. Davis, Salt Lake; D. T. Madsen, Price.

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Legislative Committee: V. L. Stevenson, Chairman, Salt Lake; Louis P. Matthei, Ogden; Clark L. Rich, Ogden; John E. Smith, Duchesne; Halvard J. Davidson, Manti; Joseph P. Kesler, Salt Lake; R. N. Malouf, Logan; Phillip B. Price, Salt Lake; E. Wayne Alred, Orem; N. F. Hicken, Salt Lake; Henry David Rees, Provo; L. V. Broadbent, Cedar City; Dean C. Evans, Fillmore; J. H. Millburn, Tooele; F. R. King, Price.

Utah Health Council: N. F. Hicken, Chairman, Salt Lake; Paul A. Clayton, Jr., Salt Lake; Q. B. Coray, Salt Lake; Howard K. Belnap, Ogden; E. B. Muir, Salt Lake; Sims E. Duggins, Panguitch.

Relations With Press, Radio and Television Committee: Dean Spear, Chairman, Salt Lake; H. C. Stranquist, Ogden; Henry David Rees, Provo; George A. Peck, Salt Lake.

Insurance Plans Committee: J. Clare Hayward, Chairman, Logan; John H. Clark, Salt Lake; Fred W. Clausen, Salt Lake; Robert G. Snow, Salt Lake; Heber C. Hancock, Ogden; Wm. J. Morginson, Salt Lake; Craig Clark, Provo.

Newspaper Health Column Committee: Q. B. Coray, Chairman, Salt Lake; A. W. Middleton, Salt Lake; Y. D. Eskelson, Salt Lake; Keith F. Farr, Ogden; R. Raymond Green, Heber City; Preston Hughes, Spanish Fork.

SPECIAL COMMITTEES

Civilian Defense Committee: Leslie J. Paul, Chairman, Salt Lake; LeRoy A. Wirthlin, Salt Lake; M. P. Southwick, Ogden; Riley G. Clark, Provo; Joseph P. Kesler, Salt Lake; Morgan S. Coombs, Salt Lake.

Constitution and By-Laws Committee: J. Russell Smith, Chairman, Provo; James M. Catlin, Ogden; R. O. Johnson, Murray; Garner B. Meads, Salt Lake; C. Louis Jorgenson, Ogden; Galen O. Beldon, Salt Lake.

Blood Bank Committee (other members to consist of the chairmen from the Blood Bank Committees of the County Component Societies): Crichton McNeil, Chairman, Salt Lake.

Advisory Committee To Woman's Auxiliary: R. O. Porter, Logan; James H. Rasmussen, Brigham City; S. M. Budge, Logan; L. H. Merrill, Hiawatha; John B. Cluff, Richfield; James F. Orme, Salt Lake; R. G. Williams, Cedar City; T. R. Seager, Vernal; R. E. Jorgensen, Provo; Rich Johnston, Ogden.

Neurology Committee: L. A. Stevenson, Chairman, Salt Lake; James K. Palmer, Salt Lake.

Rheumatic Fever Committee: L. G. Veasey, Chairman, Salt Lake; A. A. Jenkins, Salt Lake; Joan Critchlow, Salt Lake; Homer R. Rich, Ogden; Don C. Merrill, Provo; John K. Wright, Price; Ralph N. Barlow, Logan; Kenneth A. Crockett, Salt Lake; Ralph Carlson, Ogden.

Veterans Affairs Committee: Vernon L. Stevenson, Chairman, Salt Lake; V. H. Johnson, Ogden; W. E. Peltzer, Salt Lake.

Geriatrics Committee: Victor Kassel, Chairman, Salt Lake; Vernon L. Ward, Ogden; G. B. Madsen, Mt. Pleasant; LeRoy A. Wirthlin, Salt Lake; L. W. Sorenson, Parowan; A. J. Lund, Ogden; Glenn B. Orton, Springville.

Planning Committee: Alan Macfarlane, Chairman, Salt Lake; Donald M. Moore, Ogden; R. O. Porter, Logan; Charles Ruggeri, Jr., Salt Lake.

Budget Committee: Alan P. Macfarlane, Chairman, Salt Lake; R. O. Porter, Logan; Charles Ruggeri, Jr., Salt Lake; James Z. Davis, Salt Lake; Donald M. Moore, Ogden.

Building Committee: Charles Ruggeri, Jr., Chairman, Salt Lake; James Z. Davis, Salt Lake; Homer E. Smith, Salt Lake; R. O. Porter, Logan.

Special Committee on Hospital Rules and Regulations: Frank K. Bartlett, Chairman, Ogden; John Z. Brown, Jr., Salt Lake; Joseph P. Kesler, Salt Lake; Gail W. Haut, Price; Lionel W. Sorenson, Parowan; Talmadge M. Thomson, Pleasant Grove; William M. Nebeker, Salt Lake.

Resolutions Committee: Eliot Snow, Chairman, Salt Lake; J. Poulson Hunter, Salt Lake; Wallace S. Brooke, Salt Lake; George M. Fister, Ogden; Ray E. Spendlove, Vernal; James Z. Davis, Salt Lake; Henry C. Stranquist, Ogden; J. Russell Smith, Provo; Gail W. Haut, Price; L. V. Broadbent, Cedar City.

Medical-Legal-Insurance Study Committee: Wm. M. Nebeker, Chairman, Salt Lake; Paul S. Richards, Salt Lake; (the balance of this committee consists of the Council members).

Nominating Committee For 1956: (Appoint six in May of 1956).

THE WYOMING STATE MEDICAL SOCIETY

NEXT ANNUAL MEETING: JUNE 27-30, 1956; JACKSON LAKE LODGE, MORAN

OFFICERS, 1955-56

President: Russel I. Williams, Cheyenne.

President-elect: Joseph Hellewell, Evanston.

Vice President: H. B. Anderson, Casper.

Secretary: Benjamin Gitlitz, Thermopolis.

Treasurer: C. D. Anton, Sheridan.

Delegate to A.M.A.: W. Andrew Bunten, Cheyenne.

Alternate Delegate to A.M.A.: Albert Sudman, Green River.

Executive Secretary: Arthur R. Abbey, Cheyenne, Box 2036.

Councilors: Glen O. Beach, 1956, Casper; Joseph Whalen, 1956, Evanston; Joseph E. Hoadley, 1957, Gillette; Francis A. Barrett, 1957, Cheyenne; Wm. Hinrichs, 1958, Douglas; Loran B. Morgan, 1958, Torrington; Neis Vickland, 1956, Thermopolis; R. I. Williams, Chairman (Ex-Officio), Cheyenne; Benjamin Gitlitz, Secretary (Ex-Officio), Thermopolis.

COMMITTEES

Committee For Profesional Review: James Sampson, Chairman, 1958, Sheridan; Albert Sudman, 1956, Green River; George Phelps, 1957, Cheyenne; Charles Lowe, 1958, Casper.

Advisory Committee to Selective Service on Procurement and Assignment of Physicians: Sam Zuckerman, Chairman, 1958, Cheyenne; James W. Sampson, 1957, Sheridan; Joseph A. Gautsch, 1956, Cody.

Blue Cross Trustees: Eugene Pelton, 1958, Laramie; Lowell Kattenhorn, 1956, Powell; L. H. Wilmoth, 1957, Lander; Frederick Haigler, 1959, Casper.

Blue Shield Trustees: W. A. Bunten, 1956, Cheyenne; Mr. Earl Bower, 1956, Worland; Lowell Kattenhorn, 1956, Powell; George Phelps, 1956, Cheyenne; Edward Guilfoyle, 1957, Newcastle; Mr. Byron Hirst, 1957, Cheyenne; James Sampson, 1957, Sheridan; Royce Tebbet, 1957, Casper; Rudolph Anselmi, 1958, Rock Springs; Francis Barrett, 1958, Cheyenne; G. W. Koford, 1958, Cheyenne; Brenden Phibbs, 1958, Casper.

Rocky Mountain Medical Conference: H. L. Harvey, Chairman, 1957, Casper; Earl Whedon, 1958, Sheridan; Don MacLeod, 1956, Jackson; J. B. Gramlich, 1958, Cheyenne; Brenden Phibbs, 1958, Casper; R. P. Fitzgerald, 1958, Casper; G. W. Koford, 1958, Cheyenne.

Public Relations Committee: H. B. Anderson, Chairman, Casper; Bernard Stack, Riverton; S. J. Glovale, Cheyenne; and all 1955 County Medical Society Presidents.

Maternal Welfare: L. H. Wilmoth, Chairman, Lander; O. J. Rojo (Military Service), Sheridan; L. D. Kattenhorn, Powell; Clark Young, Casper; B. J. Sullivan, Laramie; W. M. Franz, Newcastle.

Child Health Committee: O. K. Scott, Chairman, Casper; Lawrence J. Cohen, Cheyenne; Lucile B. Kirtland, Story; L. F. Allison, Powell.

Cancer Committee: Charles Lowe, Chairman, 1956, Casper; Joseph A. Gautsch, 1956, Cody; Karl Krueger, 1957, Rock Springs; Dan B. Greer, 1957, Cheyenne; Franklin Yoder, 1957, Cheyenne; Jack Rhodes, 1958, Sheridan; John Gramlich, Cheyenne.

Mental Health Committee: Don W. Herrold, Chairman, Cheyenne; Joseph Whalen, Evanston; Franklin Yoder, Cheyenne; William Rosene, Wheatland.

Medical Economics Committee: E. C. Pelton, Chairman, Laramie; J. Cedric Jones, Cody; A. J. Allegretti, Cheyenne; Brenden Phibbs, Casper; Ben Leeper, Cheyenne.

Advisory Committee to Woman's Auxiliary: Wilber Hart, Chairman, Casper; Edward Guilfoyle, Newcastle; Robert Black, Cheyenne.

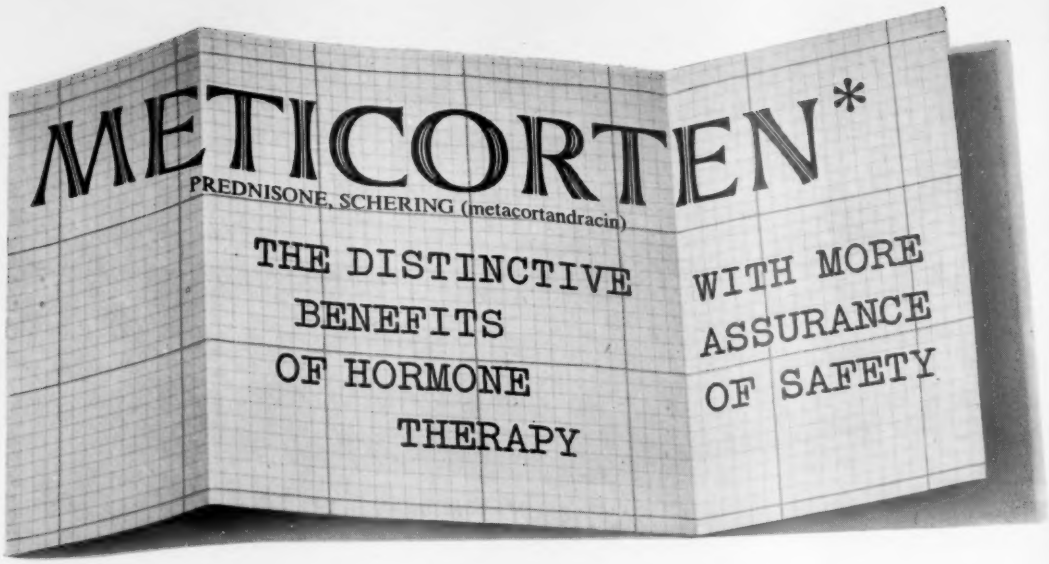
Public Policy and Legislation: G. W. Koford, Chairman, 1958, Cheyenne; DeWitt Dominick, 1956, Cody; Norman R. Black, 1957, Cheyenne; E. C. Pelton, 1957, Laramie; R. P. Fitzgerald, 1958, Casper; L. H. Wilmoth, 1957, Lander; C. D. Anton, 1956, Sheridan; G. Myron Harrison, 1956, Rock Springs; J. W. Sampson, 1958, Sheridan.

State Institutions Advisory Committee: Joseph F. Whalen, Chairman, Evanston; Franklin D. Yoder, Cheyenne; R. H. Kanable, Basin; James Cashman, Rawlins; L. H. Wilmoth, Lander; Guy Halsey, Rawlins; John H. Froyd, Worland.

Council on National Emergency Medical Service Civil Defense: George Phelps, Chairman, 1958, Cheyenne; Roscoe H. Reeve, 1958, Casper; E. W. DeKay, 1957, Laramie; John J. Wild, 1957, Sheridan; Bernard Stack, 1956, Riverton; Richard Stratton, 1956, Green River; Benjamine Gitlitz, 1956, Thermopolis.

Judicial and Advisory Committee (Workmen's Compensation): District No. 1, K. N. Petri, 1956, Laramie; D. M. Kline, 1956, Cheyenne; Francis Barrett, 1958, Cheyenne; District No. 2, J. G. Wanner, 1957, Rock Springs; District No. 3, J. H. Waters, 1957, Evanston; District No. 4,

(Continued on Page 952)



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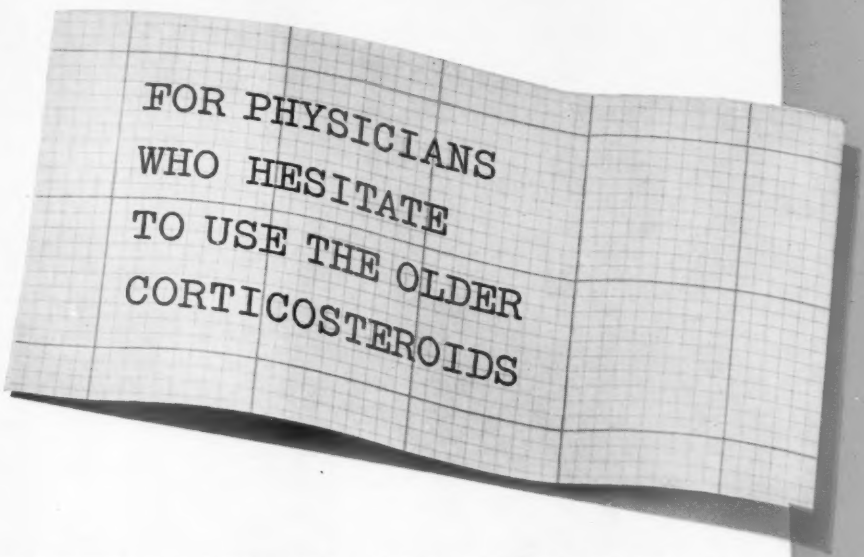

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(Continued From Page 948)

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American Medical Education Foundation: Benjamin Gitlitz, Chairman, 1958, Thermopolis; Norman B. Halley, Laramie; E. W. McNamara, Rawlins; E. George Johnson, Douglas; E. E. Callaghan, Riverton; J. E. Volk, Torrington; W. H. Pennoyer, Cheyenne; Robert Fowler, Casper; S. Thickman, Sheridan; Howard Greaves, Rock Springs; Donald Daines, Evanston; J. E. Hoadley, Gillette; David Gregg, Greybull.

Necrology Committee: Franklin D. Yoder, Chairman, Cheyenne.

Rural Health Committee: John B. Krahl, Chairman, Torrington; J. E. Hoadley, Gillette; William A. Hinrichs, Douglas; O. L. Treloar, Afton.

Gottsche Estate: Franklin Yoder, Chairman, Cheyenne; Tom Nicholas, Buffalo; O. K. Scott, Casper; Nels Viclund, Thermopolis; L. H. Wilmoth, Lander; Karl Krueger, Rock Springs.

Advisory to the Easter Seals Committee: Albert R. Taylor, Chairman, Cheyenne; Duane M. Kline, Cheyenne; S. S. Zuckerman, Cheyenne; J. A. Gautsch, Cody; Nels Vicklund, Thermopolis.

Credentials Committee: Ben Gitlitz, Chairman, Thermopolis; Carleton D. Anton, Sheridan; Joseph S. Hellewell, Evanston.

Poliomyelitis Committee: L. J. Cohen, Chairman, Cheyenne; O. K. Scott, Casper; Franklin D. Yoder, Cheyenne; H. B. Anderson, Casper; Duane Kline, Cheyenne.

Time and Place Committee: Joseph Hellewell, Chairman, Evanston; Chairman of Delegation from Northwestern Society; Chairman of Delegation from Natrona County; Chairman of Delegation from Converse County; Chairman of Delegation from Goshen County.

Resolutions Committee: President-Elect, Joseph Hellewell, Chairman; Vice President, H. B. Anderson; Chairman of the Delegation from Uinta County; Chairman of Delegation for Northeastern Society; Chairman of Delegation from Sheridan County.

Nominating Committee: President, Chairman-Secretary and Treasurer; Past Presidents, Past Secretaries, Past Treasurers; Chairman of the Delegation from Albany County; Chairman of the Delegation from Carbon County; Chairman of the Delegation from Sweetwater County; Chairman of the Delegation from Laramie County.

Parliamentarian: Joseph Hellewell, Evanston.

Laboratory and Blood Bank Committee: Donald Becker, Chairman, Casper; Sam Zuckerman, Cheyenne; John Froyd, Worland; Willis Franz, Newcastle.

Historical Committee: Francis A. Barrett, Chairman, Cheyenne; William Hinrichs, Douglas; Franklin D. Yoder, Cheyenne; James W. Sampson, Sheridan.

Constitution and By-Laws Committee: H. B. Anderson, Chairman, Casper; Ted Holman, Casper; William Hinrichs, Douglas; William Rosene, Wheatland.

Cardiovascular and Renal Diseases: A. J. Allegretti, Chairman, Cheyenne; Charles Lowe, Casper; Seymour Thickman, Sheridan; Lloyd Evans, Laramie.

Arthritis Committee: David M. Flett, Chairman, Cheyenne; Myron Harrison, Rock Springs; Chester Ridgway, Cody.

Blue Shield Fee Schedule Committee: (Not completed at this time).

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President: Charles K. LeVine, Beth Israel Hospital, Denver.

President-Elect: J. R. Peterson, Larimer County Hospital, Fort Collins.

Vice President: Sister Mary Jerome, Mercy Hospital, Denver.

Treasurer: M. A. Moritz, Denver General Hospital, Denver.

Executive Secretary: C. F. Fielden, P. O. Box 1216, Colorado Springs.

Trustees: Esther Thornton (1955), Washington County Hospital, Akron; Henry H. Hill (1955), Weld County Hospital, Greeley; Hubert Hughes (1955), General Rose Memorial Hospital, Denver; Robert A. Pontow (1956), University of Colorado Medical Center, Denver; Roy Prangley (1956), St. Luke's Hospital, Denver; Msgr. John R. Mulroy (1956), Catholic Charities, Denver; Roy Anderson (1957), Presbyterian Hospital, Denver; Harry Clark (1957), Southwest Colorado Memorial Hospital, Cortez; Elton A. Reese (1957), Alamosa Community Hospital, Alamosa.

Delegates: Louis Liswood, National Jewish Hospital, Denver; Harley E. Rice, Alternate, Porter Sanitarium and Hospital, Denver.

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Shredded new cabbage and carrot slaw goes nicely with any meal, and combines the benefits of vitamins A and C with some calcium.

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Pork in the Dietary
During Pregnancy and Lactation

CERTAIN NUTRIENTS are required in greater than normal amounts during pregnancy and lactation. Pork meat, though its cost is low, supplies a remarkably high quantity of the nutrients required by the maternal organism in these periods of physiologic need

During pregnancy the maternal organism may store 3.3 to 5.5 pounds of protein in excess of that contributed to fetal tissue.[1] Enough iron is stored to approximate the entire amount secreted in the milk during 9 months of lactation, in addition to the iron supplied to the fetus.[2]

The body of the newborn infant contains approximately 500 grams of protein, 14 grams of phosphorus, and 0.5 gram of iron.[3] It is estimated that the lactating mother, through breast milk, provides a 26 week old infant with about 12 grams of protein, 76 grams of lactose, and 1.2 mg. of iron each day.[2]

Pork meat, an excellent source of high quality protein, thiamine, niacin, and iron,[4] also supplies valuable amounts of other B vitamins, as well as phosphorus, magnesium, and potassium. The thiamine content of pork is particularly important, since there are few more valuable food sources of this vitamin.[4]

Pork and pork sausage—economical, good tasting—are valuable components of the dietary of the pregnant or lactating woman. Just how valuable, is shown in the table below.

1. Toverud, K.U.; Stearns, G., and Macy, I.G.: Maternal Nutrition and Child Health, an Interpretative Review, Washington, D.C., National Research Council, Bull. 123, 1950.
2. McLester, J.S., and Darby, W.J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W.B. Saunders Company, 1952, p. 241.
3. Marrack, J.R.: Food and Planning, London, Victor Gollancz, Ltd., 1943, p. 67.
4. Wolgamot, I.H., and Fincher, L.J.: Pork Facts for Consumer Education, Washington, D.C., United States Department of Agriculture, AIB No. 109, 1954.
5. Watt, B.K., and Merrill, A.L.: Composition of Foods—Raw, Processed, Prepared, Washington, D.C., United States Department of Agriculture, Agricultural Handbook No. 8, 1950.
6. Bowes, A. deP., and Church, C.F.: Food Values of Portions Commonly Used, ed. 7, Philadelphia, Anna dePlanter Bowes, 1951.

Percentages of Recommended Daily Dietary Allowances* for Pregnant (3rd Trimester) and Lactating Women Provided by 3-Ounce Portions of Cooked Pork Meats and Pork Sausage

	Protein	Iron	Phosphorus	Thiamine	Riboflavin	Niacin	Calories
PREGNANCY (3rd trimester)							
Ham, without bone, 3 oz., cooked[5]	25.0%	17.3%	13.5%	30.0%	10.0%	26.7%	12.5%
Pork Chops, without bone, 3 oz., cooked[5]	25.0%	17.3%	13.3%	47.3%	10.0%	28.7%	10.5%
Pork Sausage, 3 oz., cooked[6]	17.3%	14.0%	9.2%	27.7%	10.1%	18.5%	14.7%
LACTATION							
Ham, without bone, 3 oz., cooked[5]	20.0%	17.3%	10.1%	30.0%	8.0%	26.7%	10.2%
Pork Chops, without bone, 3 oz., cooked[5]	20.0%	17.3%	10.0%	47.3%	8.0%	28.7%	8.6%
Pork Sausage, 3 oz., cooked[6]	13.8%	14.0%	6.9%	27.7%	8.1%	18.5%	12.0%

*Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953

The nutritional statements made in this advertisement have been reviewed and found consistent with current medical opinion by the Council on Foods and Nutrition of the American Medical Association.

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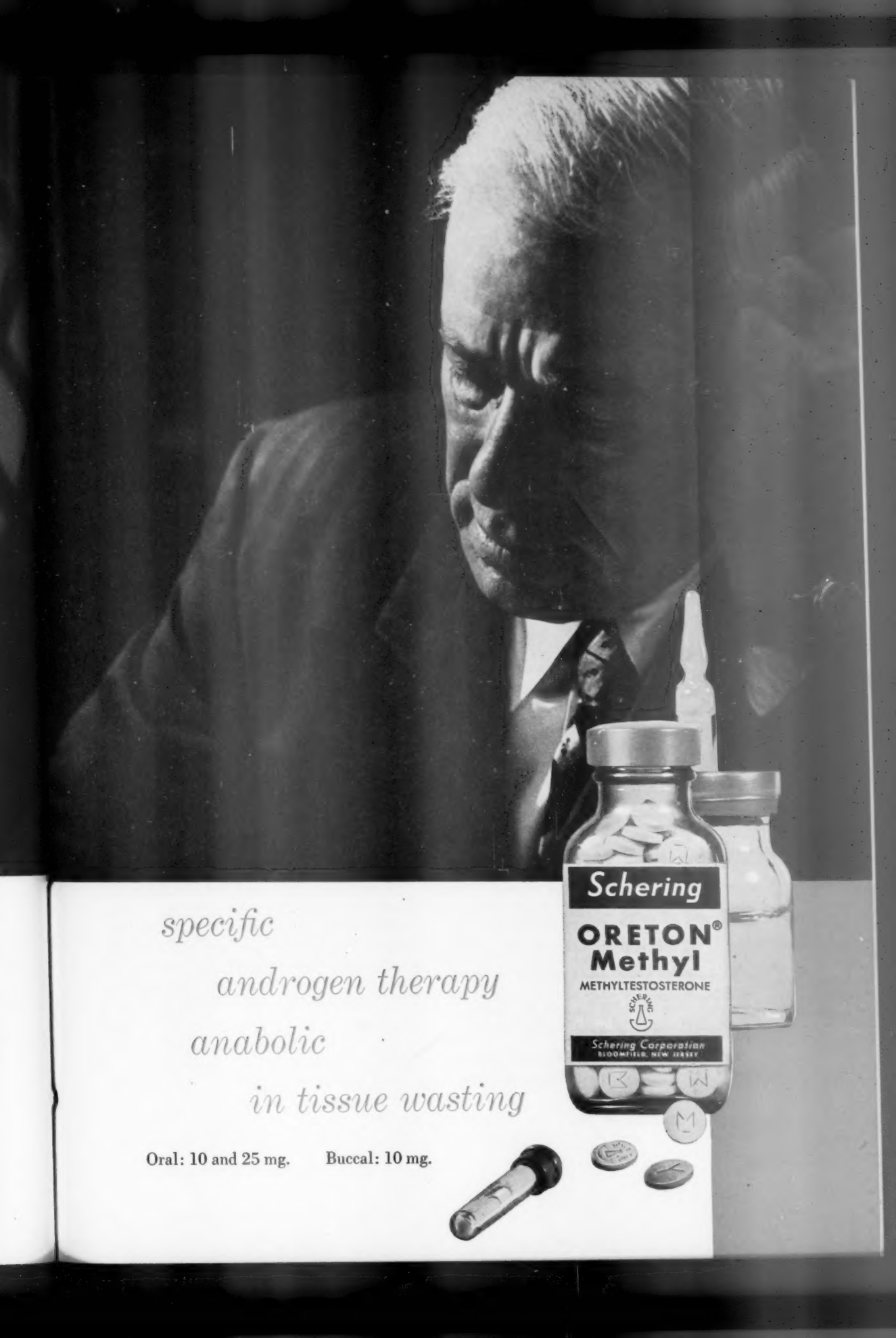

specific

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Oral: 10 and 25 mg. **Buccal: 10 mg.**

Rocky Mountain Medical Journal

NOVEMBER, 1955

Colorado - Montana - New Mexico
Utah - Wyoming

A Real Victory

DECENCY in the healing arts triumphed again last month when a Denver District Court dismissed the eleven-million-dollar suit which Chiropractor Leo L. Spears and his "Spears Free Clinic and Hospital for Poor Children, Inc.," had prosecuted against the Denver Area Better Business Bureau, the Denver Post, the Colorado State Medical Society, and some eighty other defendants including all the members of the Board of Directors of the Better Business Bureau. Spears had accused all the defendants of conspiracy to destroy his "institution" and alleged that they had caused him great loss of business.

Not only was the court's verdict a victory both actual and moral for those in and out of the medical profession who for years have disapproved and deplored the advertising practices followed by the Spears sanitarium on a national scale. It was more than that, because it laid down for the first time in many years in the Rocky Mountain region a court's clear support of principles of law in the professional licensing acts which are of vital interest to medicine, dentistry and nursing, and their relation to hospital administration.

The decision constituted direct court support of the principle that a corporation may not practice a profession the very nature of which requires personal examination and licensing of an individual person. The laws, one can plainly see by reading them, state this clearly, but some who would like to escape these provisions of law have too often in recent years exhibited a growing trend toward "avoiding" the law by one or another subterfuge, or by plainly ignoring it.

The significance of the court decision goes far beyond our own professional or editorial opinions concerning the value of any chiropractic treatment, beyond our own opinions concerning the validity of any claim of the Spears sanitarium that it is a "charitable" or "non-profit" institution, even beyond the fact that the court found no "conspiracy" existed among the defendants and found that the sanitarium had not been damaged by them.

The significance is found in quotations from the court's decision:

"It would be strange indeed if the law would afford legal protection to a business which in its very manner and method of operation violates the law."

After reiterating the definition of the practice of medicine as set forth in the Colorado Medical Practice Act of 1951, the court's opinion stated: " . . . . Most certainly the plaintiff corporation is practicing medicine under each of these statutory definitions of that phrase."

Referring to the claim of the plaintiff chiropractic sanitarium that it is operating not for profit and in part as a charitable institution:

"It ill behooves a trial court to ingraft an exception upon that rule to the end that a 'non-profit' corporation would be exempt from the application of this rule. If the reason for the rule that a corporation cannot practice medicine or dentistry is an expressed legislative desire to protect the public against unauthorized, unqualified and improper practice of the healing arts, and to maintain the personalized relationship between the healer and the patient, then whether a corporation was organized for profit or non-profit would be of no legal significance.

"If such exception is to obtain, then any group of persons could organize a 'non-profit' corporation, put themselves on the payroll and, as members of the board of directors, then set their salaries as high as they want to, and thereafter practice medicine or surgery or dentistry or chiropractic or law. Our Colorado decisions simply do not permit such."

Many strong and undoubtedly sincere differences of opinion have been expressed in recent years, not only in Colorado, but in Utah, New Mexico, Iowa, Ohio and many other states, regarding the rectitude of hospitals employing specialists on salaries to operate certain diagnostic services, then including fees for such services as part of the hospital bill. Some hospital leaders thought that because such practices had been carried on for a great many years, slowly growing, that there was a "tradition" behind them that should make them legal—and, if illegal, that laws should be changed to legalize them. The medical profession thought otherwise. In Colorado the dispute reached the newspapers and became a public controversy for several months in 1954. Under guidance of the state's Attorney General and a Board of Medical Examiners which voted unanimously to hew to the law as written, all interested parties were finally brought together and a system was worked out which has at least temporarily quieted the controversy. Hospitals and their pathologists and their radiologists and their anesthesiologists altered their contractual relationships to comply with the law and to draw the line cleanly between hospital services and physicians' services.

In Iowa a similar controversy is even now being tried in the courts.

Perhaps all of these cases, certainly at least one of them, will have to be heard and re-heard by the highest courts in the land before the principles are laid down with the definitive finality that is needed. However, we do editorially congratulate the State of Colorado, its business leaders, its medical organizations and their attorneys upon the establishment of another milestone along the road of protecting the public from improper practices in the healing arts. We cannot help but recall that it was the dental profession of Colorado, back in the early 1920's, which set the first milestone on this same road when it instituted the famous case against "Painless Parker." In that case the Colorado Supreme Court handed down a history-making decision (unsuccessfully challenged before the Supreme Court of the United States) condemning the corporate practice of any learned profession the practitioners of which must be personally examined as to their training and fitness to pursue their calling.

Survival of Worthy Insurance Contracts

CLERICAL work has become a major element in the practice of medicine. The specialties, particularly those entailing considerable surgery, rarely deal with any patient who does not have a form or forms to fill out. Some offices require at least one extra employee for this purpose—and the trend is here to stay. Think of the patients who bring their insurance policies, feeling that they are practically legal tender to be used at the time of need. And, consider the disappointment when conscientious honest people have paid premiums in good faith for years only to find that theirs is one of the companies so generous that they would go broke were it not for the fine print! Fortunately, much has been done to expose those companies which have written and sold many thousands of almost worthless cancellable policies. News-

paper and magazine articles set many people thinking, and many were put on the right track to procure policies which would serve them fairly and adequately. Unfortunately, however, the articles have simmered down and many people are still throwing their money away.

Growth of the better companies is gratifying as clients learn the value of their contracts and realize that there are no bargains in insurance. Hospitals have come to depend upon these contracts for their financial security—and less and less upon collection agencies. Do these contracts mean as much to the doctor? We are still trading knowledge and skill for the product of our patients' working time.

Whether our revenue comes from an insurance contract or the patient himself should be of little or no concern to us. Our fees should be reasonable in either case, regardless of the type or amount of insurance protection that the patients have procured. We and our representatives have tried to prevent insurance companies from setting our fees at less than reasonable sums. By the same token, we should never charge or accept from them more than is reasonable. Anyone knows what is thought of a merchant or tradesman who charges more for his wares or his service in order to chisel into the jackpot of a company, corporation, or government. Doctors who do the same are few, but even one of them undoes the good will and favorable public relations built up by hundreds of honest physicians. Dr. H. Berger said, "Just remember that there's a protagonist for medical care by government in every individual who's had a hard time paying for a costly operation."

Taxpayers have paid a large part of the cost of medical education, and to them we have an obligation, notwithstanding the fact that we also pay our share of taxes, more and more in proportion to our success. Such is the system of taxation in the prevailing social and economic order. The cost of our education and life-long payment of taxes is a small consideration compared with humanitarian service and the custody of our nation's health, our greatest obligation.

The question arises as to whether state medical associations have the right and power to control the practice and behavior of their members. The answer is, we believe, preponderantly yes, and even to the extent of dismissal of the few unworthy and uncontrollable members. One of our state medical journals has stated editorially that the findings of the Grievance Committee should be published in the Journal when a member is found guilty of unfair practice. This is a progressive thought indeed, and one fraught with some dangers, but perhaps the time has come when we should invoke whatever it takes to steer the American ship of medicine smoothly and openly in full view of enlightened public relations!

Loyalty to Blue Cross - Blue Shield

YOUR attention is called to an article featured in this issue of your Rocky Mountain Medical Journal. It is entitled "What Your Blue Shield Means To You" by Dr. Francis T. Hodges of San Francisco; it was presented at the annual meeting of the Wyoming State Medical Society at Laramie, in June.

This article is not just another treatment upon prepayment medical plans. It is one of the finest of its kind among the many which has come to our attention. Turn to page 980 and read this splendid article. There are a lot of facts for you to carry in your head and pass on to patients whenever the opportunity arises. For example, many commercial companies are only paying 30 to 50 per cent of income back to their clients in the form of benefits; Blue Shield averages about 91 per cent. Of course, Blue Shield is our Plan, but hasten to emphasize the fact that it is also the people's Plan! Its success and survival depends upon us—and, in the long run in America, our survival as a free-enterprise profession probably depends upon it.

Read the article, Doctor! It is worth your time.

*Presidential Address**

ROBERT T. PORTER, M.D.
Greeley

FROM time to time one hears the statement "medicine is at the crossroads." Physicians and laymen, thinking of the political situation in the world today, frequently become pessismistic and think, quite honestly, that there is little future for the profession. It is easy to accept this philosophy, but I can think of no field of human endeavor where the progress has been as great and the road as straight as it is in scientific medicine. When atomic energy and its related developments were new, medicine took from them that which was good and usable. The same has been true in other fields. Wherever there have been new developments that medicine could use, it has adopted them. At the same time, scientific medicine has been pushing ahead even more rapidly on its own. One need only think back twenty years to realize that the medicine of today is almost an entirely different science than it was at that time. So I say to you, scientific medicine is never at the crossroads.

Socio-economic medicine is a field in which we have been a little less active in the past but in which we are now catching up, and in which we must continue to drive forward. Here some question might be raised as to whether or not medicine is at the crossroads. Many times we have had to be on the defensive in medicine, taking the negative stand against dangerous social and legislative changes. This has been inevitable. While we must always, as we have in the past, ceaselessly oppose those legislative changes which are bad, we must now try to develop for the people of our country a positive program. In large part, we must provide the leadership for that program. We should consider the welfare and health of all people and strive to achieve what is best for them both in the scientific and economic phases of medicine. We need to seek out new ideas in the socio-economic field, just as we have in the scientific, so that the two may keep pace. In no sense am I advocating socialized medicine or any of its accomplices, but certainly there is room for continuing advance in our handling of this problem. We can always remember that the belief that Galen had all the answers to medical problems held back the progress of scientific medicine for two to three hundred years. Nothing can remain static and live. Therefore we should be ever ready to accept and improve all ideas that will be good for the profession and humanity as a whole.

Some of these goals must be achieved, in part, at the county medical society level. What may a county society do to aid in the development of this socio-economic program? It is my feeling that most of this change must come at the county level through a thorough understanding of the problems which are to be faced. The entire matter of low income medical care, political, labor, and local difficulties fall into this area. I would like to suggest a plan which is not new nor developed by me. That is, that every county society spend at least twenty or thirty minutes each month discussing one phase of these problems. It would be advisable for a member of the society to take time to study the problem and present it, or if no informed member is available, to bring to the society an informed speaker from the outside. You might ask "what problems should be discussed?" There are many, but several could be suggested. One example is health insurance and its many difficulties. Twenty years ago, there was no such thing as an adequate health insurance program in this country. Today it has become one of the greatest of socio-economic developments, and the medical profession is in large part

*Delivered September 23, 1955, before the 85th Annual Session of the Colorado State Medical Society, Shirley-Savoy Hotel, Denver.

responsible for it. We are proud of it, and proud of the achievements that have been made by it. It has its problems and we, as physicians, can damage it irreparably if we are not continuously aware that these are present. I am sure that you are all cognizant of some of these problems, such as over-utilization, resulting in greatly increased cost, inadequate plans, and the like. As you well know this over-utilization is due to faults of both the patient and the physician. I need not discuss them more, for you are all aware of them, but they should be discussed in your society meetings and an attempt should be made to develop some method of solving the most glaring ones. Along this line, we must learn to be honest with ourselves and give honest criticism and even censure to our own members when they are abusing programs of this type, for without doubt, these plans are among our greatest defenses against the socialization of our profession. Sometimes we have been criticized by outside sources for censuring our own members, but who else has the knowledge or ability to do it honestly and fairly?

In addition to correcting the faults which are present in the handling of these insurance plans, we must inform ourselves regarding the various programs which are available in order to aid our patients in selecting the one best fitted to their particular needs. There are many insurance programs today that are entirely inadequate. Frequently the patient is unaware of this, and has the false sense of security which goes with the feeling that he has adequate health and accident insurance.

There is a real menace facing organized medicine today, of which you will hear much in the next few months. As many of you know, the House of Representatives by a 372 to 31 vote, passed an Amendment to the Social Security Act which would lower the eligibility age for receiving social security payments, for women, to the age of 62, and for the totally disabled, to the age of 50. At first this seems like a fine, humanitarian program, but the hidden danger is so great that the leaders of our profession feel that it is another entering wedge to Socialized Medicine, and one that would rapidly lead to our Socialization as a Profession. Immediately after the passage by the House of this Bill, upon which the Senate fortunately did not act, but will during this winter, our Board of Trustees of the AMA met and gave out this statement—"The distance between our present medical freedom and complete Government regimentation has narrowed considerably. The remaining gap will be closed completely unless physicians throughout the nation take constructive action to educate themselves, the public, and Congressmen and Senators, during the next few months." Dr. Gundersen, Chairman of the Board of Trustees, of the AMA, had this to say — "The levying of additional social security taxes by the Federal Government in order to distribute cash benefits to the permanently and totally disabled, would inevitably be followed by Federal Control of the nation's physicians who would be forced to carry out the regulations established by the Government." The Department of Health Education & Welfare would be given the power to determine total disability and whether we wished or not, as a profession, we would inevitably be brought under governmental control in the care of these individuals. Gradually the noose would tighten. Another statement, by a man not involved in medical practice, seems to be equally significant. I am quoting from an article by A. L. Kirkpatrick, entitled "The Outlook for Social Security." The article appeared in the October-November, 1954, issue of the Journal of American Economic Security. The excerpt, one of the concluding paragraphs in his article which appears as a reprint in the Journal of American Medical Association for July 23, 1955, and which would be worth your time reading in total, follows:

> "It does seem somewhat ridiculous and selfish to have the present generation of employed persons under 65, who constitute the majority of the voters of today, voting larger and larger benefits for themselves, with any one individual and his employer so far having paid only 10 per cent or less of the actual cost of the benefits he will get when he retires, and deferring the real cost to the working population of the next generation."

I am sure that the obvious threat to all of our Profession and Society is so mani-

fest in this type of legislation, that we will all get out and strongly oppose it. If not, we are more rapidly going down the road toward national Socialism than most of us have realized.

Labor unions and their medical needs are another problem that will require much discussion through the year. It is my feeling that the working out of a reasonable program of medical care with the labor unions, is one of the greatest problems that confronts the medical profession today. Labor organizations are a threat because of their tremendous power, and as far as medicine is concerned, because of their lack of understanding of the reasons for our codes and ethics. We must work with labor to provide for them what they are seeking, if it is as is to be hoped, the best of medical care for their people. We must, however, guide them in the methods in which this is obtained. Unscrupulous practices can do nothing but lower the standard of medical care in this country. We must continue to support that basic concept of medicine, the free choice of physician. Labor has made the criticism that at times they have been exploited by the medical profession. If we have exploited labor, we must put our house in order, and if labor unions are exploiting us, and some of them may be, we must stand solidly against them. Nevertheless, it is my feeling, as it is toward every other problem that we face, that intelligent cooperation of the two organizations can lead to a reasonable and a most beneficial solution.

We are threatened from another side with the problem of socialization, in that the UN Charter revisions are due very soon. We must remember that the International Labor Organization is not dead and has already passed its resolutions for international socialization of medical care. If they were able to have the Senate accept their resolution, medicine in this country would be Socialized. The Bricker Amendment, limiting the President's treaty-making power, which we have staunchly supported because of this threat, must continue to be promoted. We need to defend ourselves against such legislation being forced upon us without adequate time to consider it.

There are many other suggestions of what the County Societies might discuss. I would make only one more, one by which all Medical Societies could very well profit, and that is to spend one evening every year or two discussing with the younger members of the Society, local socio-economic problems which they have or will come in contact. The State Society in its indoctrination course is attempting to cover some of this field. The County Societies could discuss with the young men, local problems and save them frequent embarrassment and at times even malpractice suits. These then, are a few examples.

There are problems for the State Society and the individual physician. We must not forget that there are problems which face each of us as individual physicians, and problems which face the State and National Medical organizations. We must see to it that we are ever striving to improve the quality of the medical care which we give our patients, by continually adding to the training of our members. Much of this training is done through reading of Medical Journals, but we must ceaselessly urge our members to take post-graduate courses at reasonably frequent intervals. Not only the Specialist, but the General Practitioner must continue post-graduate training. It is one of the tragic facts of our profession, as all others, that too many well trained men graduate and then due to the pressure of their duties continue to practice that type of medicine through the remaining years of their lives. Fortunately with the ready availability of post-graduate courses, and the great number of Journals, this situation is being corrected. It would seem that the American Academy of General Practice has taken a step in the right direction when they insist that their members take a certain amount of post-graduate work every two years. I am not sure, but I suspect that it would also be equally valuable if our State Licensing Boards had such a requirement.

The difficulties of evaluation of hospital privileges was brought to national attention at the last AMA meeting. It is a problem that all physicians and hospitals must face and solve in a fair and honest manner. While it is true that membership in the

various specialty Societies and Boards, are good criteria regarding a new man's ability, it is obvious that they are of only temporary worth, and finally merit alone must be the guide for hospital privileges. No one should be more aware than the medical profession of the changes that senility or disease may make in one's ability. It seems likely that the AMA Committee will come out with regulations which use as their major criteria the actual ability of the man at the time he is evaluated, and that this evaluation must occur rather frequently.

In the field of medical education, physicians who have interns and residents in their hospitals have an added obligation which at times has not been met. Occasionally it has been assumed that the intern and resident were sent to the hospital to write histories and do the work which the attending man did not care to do. It must be understood that these are training periods, and while the intern may help with certain of our problems, he is there to learn, and it is our obligation to constantly improve the quality of this training. These young men are the doctors of the future, and part of our ability and skill must be passed on to them in an effort to constantly improve their knowledge of the profession.

Another phase of this same problem, is the need of the rural communities for more physicians. There must be an attempt to interest the young General Practitioner, and I say the General Practitioner advisedly, because he fits the needs of the small community better than the Specialist, in settling in the rural communities. It seems too, that we must urge our rural communities to do all in their power to make it desirable for a young physician who has spent much time and money, to come there to practice. In no sense am I suggesting subsidies to the doctor, but the community can do many things to make it possible for the young physician to have a happy experience in it.

There are problems of malpractice which we have always had with us, and unfortunately I suppose, shall continue to have. In general, this is a matter that should be discussed at the County Society level at least once a year, but basically it is a problem of the individual. We are all aware of the fact that two things more than any others cause malpractice suits.

(1) Sending accounts to the collectors to force payment of a just bill, often causes the individual who wishes to avoid payment to file a suit.

(2) Carelessness on the part of a physician in discussing with a patient the work done by a previous physician.

It is obvious that these do not need any discussion, but that they do need frequent reiteration. In general, it should be a policy of our members not to settle malpractice suits. Carrying the suit through the Courts, even at the cost of some personal embarrassment, will do more to hinder unjustified malpractice suits than any one thing. The cost of liability insurance, of course, is a problem to all, but our Committee is doing a commendable job, and if we cooperate by cutting down the incidence of these suits, they shortly will have some help for this problem.

Private practice in the Medical School has been thoroughly discussed at this meeting. There will be a report at the Clinical Session of the AMA in Boston in November on this problem. We all want the best Medical School possible for our State. We all must cooperate in finding the method of obtaining the best Medical School, and we must all keep faith and strive and work toward that end, whatever and whenever that method is decided upon.

A final problem that we have all heard much about in the eight years since the Rich report, is that of public and press relations. We all admit that we must continually strive to improve them. The "How" is a matter for study. Public relations is ours individually, for every patient that we see is part of our public relations. A public better informed, regarding the cost of the medical procedure with which it is involved would be a great help. Press relations are more of a group responsibility involving National, State, and County Societies, as well as individual. We as physicians are often misunderstood because of a lack of understanding of the reasons for our code of ethics. We must be fair with the Press and with the public, for there are many interesting stories with which we are involved, and to which they are entitled. We

must avoid selfishness in regard to letting out news of the success of our colleagues, but we must continue to keep these news stories on a highly dignified level.

Press, radio, and T.V. relations have been helped by the State Society at its annual press, radio, T.V. dinners and by the semi-annual Code of Cooperation Committee meetings, but there is also a need for these same meetings at the County level. I have no feeling that the Press is antagonistic toward us. They may be irked because we have not given them the type of cooperation which they felt that we should have. Certainly at times we have been at fault, and at times they have not understood our reasons for failure to cooperate. I believe that we should cooperate with them at every opportunity. The Code of Cooperation developed several years ago with the Press and Radio, is not dead, in fact it has just been revised and is a vital Code. We are equally responsible for keeping it an active and usable force for better understanding between the various groups.

In conclusion, it is obvious that all of these problems will not be solved during this ensuing year. Did you ever think that there would be no need for a Medical Society if there were no problems? As is obvious from the preceding discussion, there is a greater need today for organized thinking and organized activity than at any time in the past. If at the end of the year it can be said that together we have made progress toward solving some of these problems, and that the Colorado State Medical Society is better for what has been done, then I shall consider that our year has been worthwhile.

*Hearing Problems**

CLIFFORD F. LAKE, M.D.
Rochester, Minnesota

DEAFNESS of varying degrees has undoubtedly been present throughout the history of mankind. The mechanization of agriculture, industry and warfare has contributed new problems in hearing to modern man. The causes of hearing problems in children may be classified into two groups, prenatal and postnatal.

Prenatal Group

Let us first consider the prenatal group of hearing problems.

Developmental Deafness in the Prenatal Group: Various anomalies of the ear may be present. Failure of complete development of the external ear, of the external auditory canal, of the tympanic membrane and middle ear structures, and of the inner ear structures will produce various degrees of deafness from slight to complete. Minor variations from the normal conformation of the external ear are usually of no importance from the hearing standpoint.

Various surgical procedures have been performed on the ear canal and middle ear in attempts to improve hearing. Since introduction of the fenestration operation the horizontal semicircular canal of the inner ear has been fenestrated in some instances, along with procedures on the middle and external ear, to further restore the patient's ability to hear.

A careful assessment of the defect and the hearing present must be made by the otologist before any surgical procedure is undertaken in this group of patients. The ages of 3 to 4 years are usually the earliest in which satisfactory testing and treatment can be undertaken.

Pattee[1] in 1947 and House[2] in 1953 described procedures for surgical treatment of congenital atresia of the ear canal.

Hereditary Deafness in the Prenatal Group: In some instances, deafness may be present at birth or become apparent within

*Read at the meeting of the Wyoming State Medical Society, Laramie, Wyoming, June 13 to 15, 1955. From the Section of Otolaryngology and Rhinology, Mayo Clinic and Mayo Foundation, Rochester, Minnesota. The Mayo Foundation is a part of the Graduate School of the University of Minnesota.

a few months after birth. If a family history of similar deafness can be obtained, one can then assume the child to have a true hereditary deafness. However, other possible causes of deafness should be investigated. Fowler and Basek[3] found relatively few children with clear-cut hereditary deafness in the prenatal group. They also listed deafness associated with retinitis pigmentosa and syphilis under causes during preconception.

Acquired Deafness in the Prenatal Group: Rubella occurring in the mother in the second and third months of pregnancy is an important cause of deafness in this group.

Erythroblastosis from Rh incompatibility is another important cause of deafness in the prenatal group.

Birth injury, toxemia of pregnancy, anoxemia during delivery, abortives, excessive use of drugs, otitis neonatorum and emotional disturbances with excess vomiting may all operate as causative factors producing deafness.

Postnatal Group

Except for the instances of hereditary deafness in which hearing is present at birth and rapidly diminishes in the first few months, deafness in this group is of the acquired type.

Acquired Deafness in Childhood: Secretory Otitis Media is the commonest cause of deafness in childhood. In this situation fluid of a sterile type, or mucus, fills or partially fills the middle ear and mastoid cells. This produces a conductive deafness of a moderate amount. Secretory otitis media in childhood is most often seen during and after upper respiratory infections. Acute suppurative otitis media may be followed by a secretory type. This is often seen in instances in which the acute stage has been treated with the antibiotic drugs to the point of sterilizing the middle ear, but leaving an edematous process in the middle ear, eustachian tube and nasopharynx.

An enlarged adenoid or hypertrophy of the lymphoid tissue along the lateral wall of the nasopharynx in the region of Rosenmüller's fossa is a common finding in children who have secretory otitis media. Another cause of secretory otitis media that is often unrecognized is a boggy, allergic nasal mucosa with associated edema of the eustachian tube.

The classic appearance of the eardrum in secretory otitis media is that of a slightly amber color; often the handle of the malleus will appear whiter than usual. Occasionally the drum will have a faint pink discoloration, and under examination with a magnifying otoscope a slight injection of the vessels over the tympanic surface will be observed. More rarely will be seen a discoloration of the drum which can best be described as pearly or opalescent. This may be accompanied by a slight appearance of fullness, and when present suggests the possibility of a clear secretion, or mucus, which may be very tenacious, in the middle ear.

The treatment of secretory otitis media in childhood consists of removing the fluid from the middle ear by myringotomy, eradicating lymphoid tissue from the nasopharynx when present, clearing infections from the respiratory tract and treating allergic conditions when present. Direct-vision radical adenoidectomy often produces satisfactory results especially when the lateral walls and recesses of the nasopharynx contain moderate to large amounts of lymphoid tissue. Occasionally, roentgen therapy to the middle ear, eustachian tubes and nasopharynx can be employed with benefit. Radium applications to the nasopharynx and eustachian orifices may be of value in certain instances. The antihistaminic drugs may be of distinct value in instances in which a history of allergy can be obtained or in which there are definite findings of nasal allergy. This is especially true in instances in which congestion of the middle ear without fluid simulates secretory otitis media.

It is obvious that prevention of recurrence is the goal to be striven for in the treatment of chronic secretory otitis media. The general health of the child should be considered and whatever measures are necessary for improvement should be undertaken.

Acute Suppurative Otitis Media: Recurring acute suppurative otitis media with

subsequent scarring of the tympanic membrane and structures of the middle ear is another cause of deafness in childhood. Fortunately, myringotomy, the sulfonamides, and more recently the antibiotic drugs or a combination thereof have reduced the number of instances in which this condition results in deafness. Early and adequate treatment of acute otitis media should result in resolution of the process without residual hearing loss. When indicated, mastoidectomy should be done.

Chronic Suppurative Otitis Media: Chronic suppurative otitis media is less often seen since the advent of the sulfonamide and antibiotic drugs. When present, a conductive deafness results. Every effort should be made to clear up the infection. In some instances surgery will be necessary, and when possible a modified-type radical mastoidectomy with preservation of the ossicular chain should be done in order to preserve the hearing present.

In instances in which a dry ear has been obtained, the perforation can sometimes be closed with resultant improvement in hearing. In this group of patients eradication of infection in the respiratory tract if present is most important.

Infectious Diseases of Childhood: Deafness may follow any of the usual childhood diseases or prolonged high fever of unknown origin.

A complete loss of hearing, fortunately usually involving only one ear, may follow mumps. Measles, scarlet fever, whooping cough, meningitis and pneumonia also may be followed by deafness of a perceptive type, or if the middle ear is involved, a conductive-type or mixed deafness may result.

Injuries to the Ear and Head: Injuries to the ear from foreign bodies and blows rupturing the tympanic membrane produce a conductive deafness. Ruptures of the tympanic membrane of this sort often can be repaired by splinting the drum with a piece of waxed paper, or a suitable piece cut from a sheet of thin plastic material. Fractures of the skull involving the inner ear or nerve of hearing will produce perceptive deafness, usually complete.

Should atresia of the external auditory canal occur from injuries such as laceration or burns, it may be necessary to skin-graft the canal at the time of surgery to get a good result.

Drugs: Streptomycin, dihydrostreptomycin, salicylates and quinine all have been known to produce deafness. The deafness from streptomycin and dihydrostreptomycin may occur after only a few injections of the drug. Ordinarily, however, this is not the case, the majority of instances occurring after prolonged treatment.

Miscellaneous: Foreign bodies in the external ear, impacted cerumen and edema of the external auditory canal from an external otitis or furunculosis all may produce deafness.

Ménière's disease with its associated hearing loss has been reported to occur in childhood. Cerebral degeneration may also be associated with deafness. Psychogenic deafness and failure of development of speech patterns may occur in infancy.

Cerebral palsy, mental retardation and aphasia may simulate deafness problems or actually be associated with deafness. Such problems as these will require the efforts of the otologist, neuropsychiatrist, pediatrician, speech therapist and above all the parents for diagnosis and treatment.

Acquired Deafness in Adult Life: Hearing problems arising in adult life are of the acquired group. The following factors are the causes of most of the hearing problems originating in adult life—presbycusis; acoustic trauma; secretory otitis; otitis media, acute suppurative type; otitis media, chronic suppurative type; otosclerosis; hereditary nerve deafness; hydrops of the inner ear; vascular accidents involving the internal auditory artery; obstructions within the ear canal; toxic drugs; injuries, external and intracranial; tumors, involving the middle ear and the auditory nerve; psychogenic deafness; and malingering.

Presbycusis: We are all familiar with the hearing problems of the aged. This type of nerve deafness is characterized by a loss of acuity for high-frequency sounds. When the loss of acuity for such sounds gradually en-

croaches on the speech frequencies, problems in hearing arise. The most notable symptoms of this type of deafness are inability to hear easily at a distance, when several conversations are going on simultaneously and when extraneous noises are present. As this type of hearing loss progresses, the patient may eventually lose his ability to hear easily a conversational voice in quiet surroundings. When this situation occurs, a hearing aid may prove valuable.

Acoustic Trauma: The hearing problems associated with acoustic trauma have increased greatly with modern mechanization. People employed in noisy surroundings are prone to lose their hearing acuity in the higher frequencies. Often a loss originates at the 4,000 double vibration level after exposure to loud sounds. A sudden explosive sound close to the ear may produce a loss of hearing. Such noises as those associated with tractor driving, riveting, working with power saws, and around noisy machinery all may produce acoustic trauma and result in what has been known over the years as "boilermakers' deafness."

The treatment is largely a matter of prevention. Various types of ear plugs have been devised. Testing indiyiduals to be employed in noisy surroundings by fatiguing the ear and checking responses before and after fatiguing has been used as a screening method and may eliminate some who are particularly sensitive to acoustic trauma.

Pre-employment audiometric examination and speech testing when indicated will screen out those individuals who already have deafness. The type of deafness, history of same, age, and previous occupations are important factors which the otologist must consider in evaluating an individual for employment in noisy occupations. Yearly audiometric examination of workers in noisy occupations should also be of benefit in discovering those who lose hearing under such conditions.

Secretory Otitis: The ear findings on examination are essentially the same in secretory otitis in adults as in children. There are a few important differences in secretory otitis found in adults as compared to that found in children. Secretory otitis in an adult is a common accompaniment of a malignant lesion involving the nasopharynx. The first consideration in diagnosis and treatment of an adult found to have secretory otitis is to rule out a nasopharyngeal malignant lesion. This will require careful examination of the nasopharynx, with the patient under anesthesia if necessary, and biopsy of suspicious-appearing tissue. It must be remembered that occasionally a malignant lesion involving the nasopharynx will not show more than a small bulge beneath normal-looking mucosa. Other tumors than malignant ones may occur in the nasopharynx and produce secretory otitis.

Most often the adult with secretory otitis will give a history of a preceding common cold, during which time a sensation developed of one or both ears feeling blocked. Occasionally the patient will notice that in certain positions, such as when he is lying down, he will be able to hear normally in the affected ear, but on arising the involved ear again feels full. This observation is explained by the fluid running into the mastoid antrum from the middle ear on lying down, and again entering the middle ear on arising.

As in children, the role of nasal allergy, respiratory infections and lymphoid tissue in the nasopharynx must be considered in the production of secretory otitis. Secretory otitis may also accompany areo-otitis.

The treatment of secretory otitis in adults is essentially the same as in children. The underlying cause should be located and treated. Usually it is necessary to remove the fluid by myringotomy and suction. Several such procedures may be necessary. Inflations of the eustachian tube have been recommended along with myringotomy; however, overzealous treatment of the eustachian tube may promote the secretory otitis rather than relieve it. Roentgen therapy to the middle ear, eustachian tube and nasopharynx has proved useful in certain instances.

Otitis Media, Acute Suppurative Type: Otitis media of the acute suppurative type occurs less commonly in adults than in

children. However, the possibility of resultant hearing loss from such an infection must always be considered and prompt and adequate treatment instituted. The treatment in adults is the same as in children.

Otitis Media, Chronic Suppurative Type: The problems in hearing in this condition in adults are essentially the same as in children. When surgery is necessary, and when the pathologic condition will allow, a modified type of radical mastoidectomy should be done in an effort to conserve the hearing.

. Otosclerosis: Otosclerosis produces a conductive deafness and in most instances after long duration is accompanied by secondary nerve degeneration. Usually the hearing loss is very gradual and may be noted in one ear for various lengths of time before both become involved. The deafness is usually noted in the ages between the late teens and mid thirties. Often there is a family history of deafness. As the deafness progresses, the patient usually notes that he can hear better in noisy places than in quiet places. Tinnitus is usually present.

Once the diagnosis is made and the deafness found to be a handicap, the decision whether to advise the fenestration operation or a hearing aid should be made. If the patient, after careful evaluation with both pure-tone audiometry and speech testing, proves to be an ideal candidate for fenestration, an estimate of an 80 per cent chance of a good result can be given. The percentage chance is less in the group that are fair candidates, and still less in those that are poor candidates for fenestration.

Hereditary Nerve Deafness: There are a few individuals with strong family histories of deafness who have a nerve-type loss. The loss of acuity often involves the middle and upper frequencies of the speech range. The handicap varies with the severity of the loss. In this situation a hearing aid is often of little value and the patient must learn to read lips and watch facial expression as an aid to hearing.

Hydrops of the Inner Ear: Endolymphatic hydrops is a rather common condition involving the inner ear. Here the deafness is of the perceptive type of a variable amount. There may be a history of fluctuation in hearing. One or both ears may be involved. Tinnitus is usually present. When vertigo and tinnitus occur with this type of deafness, the classic triad of Ménière's disease is present.

The treatment for this condition consists largely of the vasodilator drugs, restriction and elimination of sodium and fluid, and measures to relieve the anxiety so often accompanying the condition.

Vascular Accidents Involving the Internal Auditory Artery: These often produce complete loss of hearing in the involved ear. There are, however, certain hearing losses of a transient type that can be best explained on the basis of either vasospasm or temporary obstruction of the internal auditory artery. This latter group may produce a perceptive deafness of from slight to severe degree.

The treatment of this situation is hard to evaluate, since the hearing may return to normal levels without treatment. Usually the return of function occurs within a matter of twenty-four hours or less. If a definite return of function cannot be demonstrated in twenty-four hours, treatment with a vasodilating drug should be instituted.

Obstruction Within the Ear Canal: Impacted cerumen completely blocking the ear canal produces a conductive deafness. Removing the impaction relieves the hearing loss. Foreign bodies, osteomas and scarring from injuries to the canal producing stenosis of the canal all may cause conductive deafness. Foreign bodies can usually be removed with ease. It may be necessary to remove the foreign object with the patient under anesthesia. Care should be taken not to injure the canal or tympanic membrane.

Osteomas can usually be removed from the canal with preservation of the overlying skin. Stenosis of the external auditory canal usually requires a skin graft to prevent further closure.

Toxic Drugs: Quinine, streptomycin and dihydrostreptomycin all may produce varying degrees of nerve deafness. Patients who are to receive treatment with streptomycin

or dihydrostreptomycin for periods of two weeks or more should have a careful check of their hearing made as well as an evaluation of their labyrinthine function. These tests should be repeated at monthly intervals. Doses of 1 gm. of dihydrostreptomycin per day are less likely to produce either deafness or loss of labyrinthine function than larger doses. Once the deafness and loss of labyrinthine function are established, they are usually permanent.

Occasionally deafness of a perceptive type results from large doses of salicylates. In this instance, however, the hearing impairment often disappears when the drug is withdrawn.

Injuries, External and Intracranial: Injuries to the external canal producing stenosis of the canal or damaging the tympanic membrane produce a conductive deafness. Care in repairing injuries to the external ear and canal will usually prevent stenosis from occurring. If the tympanic membrane has been ruptured, a splint of waxed paper or one cut from a thin sheet of plastic may be applied to the ruptured membrane. Healing often occurs promptly. If necessary, a skin graft may be applied.

Intracranial injuries may produce varying degrees of nerve deafness. Fractures through the labyrinth or along the course of the auditory nerve in the internal auditory canal produce nerve deafness of a complete type.

Tumors Involving the Middle Ear and the Auditory Nerve: Tumors involving the middle ear only will produce a conductive deafness. However, malignant lesions involving the middle ear often involve the mastoid process and inner ear, producing a nerve-type loss. According to Bradley and Maxwell[4] results of therapy in such tumors have been poor when glomus jugulare tumors are excluded.

Chemodectomas also usually produce a nerve-type loss by involving the inner ear. Brown[5] reported his observations on six patient with such lesions proved by biopsy. Williams and Associates[6] in reviewing thirteen patients with chemodectoma of the glomus jugulare stated that in uncomplicated cases radiation therapy alone is the best treatment.

Acoustic neuromas produce a nerve-type deafness which may not be complete. A deafness of this type accompanied by spontaneous nystagmus, imbalance and decreased corneal and facial sensitivity usually indicates the presence of a tumor in the cerebellopontine angle. Any patient presenting a unilateral deafness with a combination of these symptoms and signs should have the benefit of neurologic consultation.

Psychogenic Deafness: Psychogenic deafness is occasionally seen. This type is usually seen in individuals who for some reason have tried to shut themselves away from sounds. They may exclude only certain sounds or all sounds. A careful history and evaluation of the patient as a whole are most important in this instance. Audiometric tests such as the Doerfler-Stewart test are of value in evaluating the amount of psychogenic deafness present. The skin galvanometer test also may provide useful information in this instance.

Malingering: The malingerer may offer a difficult problem, especially if he has a certain amount of basic organic deafness. Here again, a careful history and evaluation of the patient as a whole are important.

The repeated audiograms and speech testing done over a period of several days may indicate the possibility of malingering. The Stenger test performed with the audiometer will unmask most malingerers.

Summary and Conclusions

The prenatal and postnatal causes of deafness in children have been discussed. The need for cooperation among otologists, pediatricians, neuropsychiatrists, speech therapists and parents in the diagnosis and treatment of deafness in children has been emphasized.

The causes of deafness most commonly encountered in the production of hearing problems in adults have been discussed. The effect of noise in industry, agriculture and warfare in relation to hearing problems has been discussed. The need of ruling out malignant lesions of the nasopharynx in in-

stances of secretory otitis media in adults has been emphasized.

Careful handling of injuries to the external ear and canal to prevent stenosis of the external auditory canal is clearly indicated.

The results of therapy to date of malignant lesions involving the middle ear and mastoid process have been poor.

A careful evaluation of the patient as a whole is emphasized in the appraisal of those coming to us with a problem of hearing.

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*What Your Blue Shield Means to You**

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THE history and evolution of Blue Shield, both locally and nationwide, are so familiar to us who have practiced a few years as to be hardly worthy of repetition. But, because Blue Shield has been with us these several years, and because it has operated and survived during this period of good times, and sometimes leaner, it seems to have earned the right to a critical and careful analysis.

What is it about this movement, initiated by the medical profession itself, that has stimulated the lay public to seize from us the initiative, to carry it far beyond our original plans, until today over thirty million Americans subscribe? It is just that we have offered them something they have needed, and hoped for. It is that our profession, breaking with tradition, has led, rather than followed and, by openly blazing the trail in medical economics, has shown the public that it is concerned with more than mere practice of medicine. To me, it is significant beyond words that Medicine is desirous of rendering more than the proper diagnosis and the correct treatment. It has at last achieved a realization that its duty does not end with a righteous satisfaction that the best possible medical care in the world has been offered. We have shown that this satisfaction is only empty cynicism if we are not then prepared to see that it is delivered, within the economic capacity of all Americans.

As a large, overgrown, well meaning youth, I was often somewhat like a Saint Bernard pup that wishes to be a lap dog. I bowled over those I would have love me. I flattened those I would have helped. I alienated those I would have aided. And in my wake lay a bewildering succession of wrecked china shops sufficient to arouse the envy of a bull. I believe "schiemmiel" is the appropriate word.

The sharper critics of the medical profession have often so observed us. And yet, in our naivete we may fail to see that we have, of our own volition, conceived and produced in our Blue Shield movement something so advanced and progressive that we are leading, and not reacting. The outsized youth of yesterday who knew not his own strength should awaken to his maturity and the significance of that strength. No flexing of muscles is needed, only continued demonstration that they shall be used for the common good.

Prepayment of medical costs is not completely new. Even compulsory government medicine is not. Germany, under Bismarck,

*Presented at the annual meeting of the Wyoming State Medical Society at Laramie on June 15, 1955.

started during the last century. Prepayment, in one form or another, without government compulsion, has existed on a small scale in this country for a good many years. In fact, it was the undesirable feature of certain closed panel types of practice that gave rise, in the State of Washington, to the first plans that approximate today's Blue Shield principle. Doctors in that state, finding the tyranny of the all-powerful lumber companies intolerable, responded by the formation of medical service bureaus. They refused to tolerate the abuses that arose when paternistic and autocratic firms dictated to their captive doctors the nature, the quality, the quantity and the occasion of medical care. The company gave, the company withheld, or the company took away. Whim, caprice and selfish interest determined how, when, and if the so-called beneficiaries were to receive their "benefits." Furthermore, the company designated the physician who was to render this care, and in what exact manner. Any option to be exercised was to be solely that of the company. If there ever existed a horrible example of the evils that can result when medicine loses control of the practice of medicine, this was it. Company doctors, in company towns, always aware of the buttered side of their bread, quickly learned that their prime concern in practicing their profession must be ever to do so in accord with the company's dictates. This applied invariably, whether they were paid by salary or capitation. And, no matter how benign an individual company might have been, one can conceive of the vast amount of discontent that existed among the physicians and the patients consigned to them. A little reflection upon the possibilities in this sort of absolution will soon make apparent the despotic state that prevailed.

In case this described state is considered purely past history, corrected now by resulting reforms, be reminded that a vassalege of similar structure is maintained by the United Mine Workers. Here Labor has captured the doctors, who dutifully dance to the tunes called by the bosses. One can be certain that medical decisions are carefully refereed.

The subservient company doctor is not extinct, either, despite bold action by a profession as determined as that in Washington. The obedient closed panel puppet M.D. is to be found in numerous parts of our country, his counsel to his patients muffled by the baffles and filters interposed by the corporation between them.

Let us return to the aroused physicians of the Northwest, who asked themselves by what right the lumber industry was engaged in the practice of medicine. These doctors did not then originate the trite cliche, "Why should we be in the insurance business?" They restored private and free practice by devising agencies permitting patients, as free agents, to prepay costs of illness, and select their own physicians. No longer need the patient feel that his care is the result of corporate largess, nor the physician that he is the thing of the employer.

It is inadequately known in most parts of this country that here began the idea which elsewhere grew to be Blue Shield. Few areas enjoy such full support, lay and professional, for their prepayment plans. This support stems largely from a still fresh memory of what prevailed before the profession itself acted to regain control of medical practice.

When a great need exists, the means of fulfillment seems to spring variously, in many locations in many ways. And so it was with the concept of prepayment. The early beginnings of this movement, other than in the Pacific Northwest, where evolution proceeded somewhat independently, took place in several parts of the country, and were largely influenced by the great depression. The plight of the lower income people was real. Mere existence was a daily problem. Family budgets were shattered. Confrontation with a large medical bill represented immedite fiscal disaster (and still does).

American pride being what it is, few were willing to pauperize themselves, for the resistance to herding in charity clinics is strong. Given the chance, and shown the way, Americans deeply desired to pay for their own care, and to obtain it where they chose. They were willing to pay certain regulars amounts for it, but few were able

to set aside funds against major illness. The insurance industry had given little concern to these needs. Rumblings of socialization grew louder and louder.

It is often remarked that the medical profession devised Blue Shield to thwart the socializers. And some cynics, even within the profession, insist that Blue Shield should quietly expire once it had served that purpose.

True idealism exerted an influence beyond that of expediency or opportunism. I know sufficient of the founding, as a charter member of one such plan, to be convinced of the high principles of the founders, and their intentions, that what they established should be permanent, should grow, and should be available to all who needed it. I am certain that they never conceived of it as limited only to a small token segment of the populace. I am positive that its purpose was more than as a magnanimous gesture by Medicine to salvage from economic no-man's-land a group of near-mendicants. I know that they desired this to be a profoundly useful instrument for both medical and public good.

That Blue Shield and Blue Cross have grown as fabulously as they have should be a source of great pride and satisfaction to our physicians and hospitals. Our faith in our venture has been reaffirmed, many times over; what we have offered has been recognized as infinitely good.

One hears occasional expressions of alarm that we have created a Frankenstein monster which will destroy us, or that we have parted with our freedom. We may very well have *salvaged* our freedom, and our creation, most likely, has preserved for us, and for the public, the best form of medical practice. We have offered the public what it has shown it wants.

It may be granted that the original scope of Blue Shield was to provide means of prepayment for lower income families. There was no better place to start. But it is difficult to understand what objection there should be to coverage by the medical profession itself of the vast middle class, who also earnestly desire aid in budgeting of their sickness costs.

There are many reasons why Blue Shield should embrace a very representative cross-section of the American populace, if it is to exist at all, and operate efficiently. Some of these reasons bear directly upon the relationship of Blue Shield to commercial insurance companies in this field.

It was Blue Shield and Blue Cross that awakened the insurance industry to the need for coverage of sickness costs. Even more important, their competition has caused this industry to set rates that are more realistic. Better insurance returns to the doctors have also resulted.

Competition is a regulator, an equalizer, and the great commercial insurance companies have an undoubted place in medical economics. But since we in medicine *do* have a program, and, presumably, support it, let us not be so completely benign in our attitude toward commercial insurance that we fail to see its relationship to our own plans. Both can live in peace. Both have their merits. But, if our own plans are to flourish, the degree of encroachment on the areas we should cover must not be large. Insurance companies operate for the purpose of making money for their stockholders. It is natural that all operations, then, are conducted with this in mind, and the poorer risks, the less profitable groups are not written. There is no place for the aged, or special groups such as indigents, itinerants, etc., who can, under certain conditions, be written under Blue Shield. Insurance companies are interested in the excellent risk groups—those that return a profit to the company.

Recent critical analysis of certain large companies in the health insurance field led to government censure, and has demonstrated the degree to which the profit motive can be carried.

If Blue Shield is to remain a flourishing and successful public service, for such it is, its market cannot have all of the cream skimmed off the top by private insurance. Blue Shield is a public service because the "community rate" principle can operate, permitting broad protection of many people, including some of the B-grade risks, who desire protection at least as much as the

A-1's. Two vital factors make for Blue Shield success with this "expanded risk" principle. The first is the not-for-profit structure. In a neighboring state, a large company pays out only 40 to 50 per cent in benefits. I can cite certain large ones who pay only 30. Compare this with Blue Shield averages of about 91 per cent. The second factor is the service principle, which only the doctors can underwrite, for only they, as the guarantors, can render the service.

With not-for-profit operation, a community type of rate, and the service principle, Blue Shield can operate as an extremely valuable public service. This requires a high level of physician cooperation, and active, enthusiastic support. If the profession is completely docile in attitude toward commercial competition, they may thereby assent to emasculation of their own Blue Shield plan. The insurance companies desire only top-grade risks and have no interest in the corset shops, the middle aged, or groups traditionally heavy users of benefits. They have no desire whatsoever that we should not underwrite these latter. But, if those are all that are left for us to write, our community rate is lost by the wayside, and our coverage of the poorer risks, assuredly always somehow a responsibility of the profession, becomes impossible at prices they can pay. And then, once more, the reformers will be crying that Medicine shuns its responsibilities. It is our duty to see that we are aggressive in our support of Blue Shield, that we will uphold it in competition. Where professional members go along to meetings of labor groups, employees of firms, management, etc., and explain and interpret Blue Shield, those Blue Shield plans have a chance to succeed in their mission. Blue Shield is represented as being the Doctors' Plan, which it is, but its effectiveness will depend upon the proud self-identification of the doctors with their plan. When it is properly conducted, it is also the Public's Plan.

Blue Shield is not a one way street. The benefits go to the patients and they must be generous. But the fees go to the doctors, and they must be realistic. Most Blue Shield plans operated in their early years at great sacrifice to the physicians who, through their truncated fees underwrote the ventures that they could become financially secure. Almost all plans have grown to maturity, are sound, have reserves. The day of early sacrifices by the doctors should be remembered as just that. It should not be considered that the profession was content to receive a substandard fee because it had been paid by a plan.

Continuing support of Blue Shield should not be expected of Medicine merely upon the basis of idealism and adherence to a lofty principle, praiseworthy as that might be, for the doctor is confronted with his own hard facts of economics. Doctor discontent with Blue Shield has been found to be in inverse ratio to fee payments. Where a doctor, pledged to support his Blue Shield, cannot receive a fee approximating a proper one, he may feel he has sold himself down the river. His lack of praise for his plan mystifies his patients, and we can be certain that when the local leatherworkers' union meets to consider prepayment coverage, he is not there to speak for his Blue Shield.

It is mandatory that all plans reconsider the subject of fees. There are many inequities. Many have been established by caprice, on a purely arbitrary basis. There is little uniformity in the relationship of the value of one procedure to another. Often a fee schedule committee has, without serious study, established a fee for a service on the basis of what was left in the kitty after other fees were decided upon. Often a fee schedule committeeman, ruling upon fees in a branch of practice other than his own, has downgraded the other fellow because he believes that branch overpaid. However, as the result of the study of fees paid over the country, some order is being arrived at. Both in Connecticut and California, serious studies of *relative* values have been made. They are worth examination, for unit values may then establish how many tonsillectomies equal a cholecystectomy.

Most Blue Shield plans have started on the basis of surgical coverage. Even today some do not underwrite medical benefits. This is probably the reason most schedules

are weighted in favor of surgery. It is true that medical services tend to be slighted. This should be corrected if physicians who do not perform surgery are to be more than lukeworm toward Blue Shield.

Fees must, as I have observed, approximate the usual in a community. The more the various plans get on their feet financially, the more this can be. With non-profit structure, they should be more certain of paying a proper fee than a company that must satisfy the stockholders. An interesting sidelight was the experience in a western state. The fee schedule committee was considering increases in payments to the doctors, when a delegation arrived from a county society, pleading that Blue Shield not raise its fees any more because the entire medical economy of the community would be upset. Blue Shield was already paying fees normal to that area and a rise would place Blue Shield *above* the prevailing rates.

It is my feeling that subscribers desire their physicians to be paid normal fees. They should understand the relationship of a proper fee to the doctor to their own premium rates. Of course, we will always be confronted with market resistance and there are rates beyond which subscribers will not go—at least in their present state of information—regarding the facts of prepayment for medical costs. Medicine, through Blue Shield, has a task of education ahead of it. A public that asks for more and more coverage—and should have it, I believe—must be informed just why each additional benefit will cost an additional premium. It must be informed, also, as one of Blue Shield's responsibilities, just what benefits are offered. Benefits, limitations, exceptions, must be clearly spelled out, and the doctor must not be made the referee or the interpreter. It is this latter that has alienated many physicians.

A bewildered public will not remain the champions of Blue Shield. When the exclusions, the limitations, the escape clauses, loom larger than the benefits, then they are unable to distinguish Blue Shield from the sharp-practicing, barely legal commercial firm. In some cases, I feel, Blue Shield plans have based their contract structure on what they would not cover, and how to protect themselves against losses, and then have cautiously appended benefits until the expected premium pool was earmarked. I know there must be protection against abuses and disastrous losses. But there are certain subtle differences of attitude that make for a far healthier approach when planning is based upon the very maximum that can be offered. Now is a time for boldness and imagination in conceiving a form of protection that is far reaching, broad, satisfactory to physician and patient alike. An income ceiling that is so low that very few persons are truly covered by a plan is not realistic, and is considered by the public to be merely a cynical gesture by a profession that wishes praise for a service it really hasn't rendered. A realistic income ceiling, a realistic return to the doctor, and broad coverage would mark the beginning of a new day in Medicine's public relations.

It is my feeling that with education of the public in the purposes and principles of prepayment, and with greater understanding, hence greater support, from the profession, that there can be a considerable relaxation in the controls exercised by many plans to prevent overuse and abuse. If each patient and each doctor felt individual pride of ownership in his Blue Shield, so that it was obvious that abuse of the plan was an injury to something that was *his*, attitudes of caution and suspicion in the plan offices could end. Then, instead of the obvious and annoying stop-loss gimmicks that imply everyone is dishonest, we would see emphasized what one is entitled to—rather than what he may not have. The public would be happy to see less "veto-power."

All Blue Shield plans have arisen as local operations, and they remain locally autonomous, as they should be, like our forty-eight states. There is the National Blue Shield Commission as a coordinating body, and much vital cooperation between plans can thus take place. Exchange of information, mutual research, transfers between plans, and the writing of interplan contracts would be difficult without this unifying body. As more and more national contracts are writ-

ten, this interplan cooperation will become of constantly increasing importance. In fact, the whole future of Blue Shield and Blue Cross may depend upon our ability to write these national contracts. If purely local interests stand in the way, then millions of persons who should be covered by Blue Shield and Blue Cross will look elsewhere. If private insurance companies succeed, we may be disappointed. But closed panel groups may also find these contracts to their liking, particularly when their proponents have close friends in Washington. This threat is not a remote thing, as California physicians can tell you. But more important, the significance of a major failure of Blue Shield or Blue Cross would be tremendous. The social planners would resume, with new vigor, their drive for Government medicine.

Frequently, I hear colleagues refer to Blue Shield as "that great laboratory of experimentation in the field of medical economics." The time has long since passed when the subscriber felt that his premium was a research grant. And the practicing physician, to whom the Blue Shield dollar represents a larger and larger part of his income, now is reluctant to view that dollar as a discounted one. He has his right to certain fair return. The patients have a right to guaranteed services. Neither should be a laboratory animal in experimentation. Blue Shield is big business now. It is a great and responsible public trust. All have a right to expect certainty, consistency, stability and reasonable permanence.

*Recent Advances in Surgery of the Colon**

EDWARD S. JUDD, JR., M.D.
Rochester, Minnesota

THE surgeons of many years ago found that they could remove certain segments of the intestinal tract and fashion a type of end-to-end union, but they also learned very early that few, if any, of their patients survived the ordeal because of peritonitis. This led, haltingly, to the ultimate development of a multiple-stage operation variously described by Paul, Mikulicz, Block and others and modified during more recent years by Rankin and other surgeons. If the patient could not tolerate a one-stage removal, a multiple-stage operation was considered to be the only answer and, for a long time, it was taught that it was mandatory to effect this result in a very rigid type of plan. Only in recent years has the multiple-stage operation given way to a fairly standard one-stage operation carried out under ideal circumstances and attended by very low morbidity and mortality rates. The surgeon should be the first to admit that this change is not of his own doing, for it represents the culmination of a series of brilliant laboratory investigations carried out by his colleagues in the departments of bacteriology, chemistry and internal medicine. The surgeon has been alert enough to stay abreast of these developments and to apply them, whenever possible, to his constant battle against the sepsis that is peculiar to colon surgery. Therefore, it is the adjuncts to surgical care and not any dramatic triumph or spectacular change in surgical technic that should be given full credit for decreased mortality and morbidity rates.

*Read at the meeting of the Wyoming State Medical Society, Laramie, Wyoming, June 13 to 15, 1955. From the Section of Surgery, The Mayo Clinic and Mayo Foundation, Rochester, Minnesota, which is a part of the Graduate School of the University of Minnesota.

Advances in Preoperative Preparation

The patient's general physical state can now be evaluated quite accurately. Whereas in earlier years the patient suffering from a lesion of the colon might be hurried to the operating room in a depleted condition, there is no longer any excuse for this except in the direst emergency. The cardiac, pulmonary and vascular problems have yielded steadily to the relentless progress against their ravages. The surgeon of to-

day would do well to keep abreast of all of these advances.

The content of the bowel itself is most important in preparing a patient for this type of operation. The solid stool must be removed as completely as possible before operation because the bacteria present within the bowel will remain a constant threat. Mechanical cleansing of the bowel is a most important step toward accomplishing this end. This type of cleansing is combined with the use of purgatives in order to render the content more liquid and to allow much better opportunity to attack the bacteria by some chemical or antibiotic means. At present we find at the Mayo Clinic that at least two days in the hospital seem to be an ideal length of time for carrying out this program of mechanical cleansing and purgation.

After the excellent results obtained with the sulfonamide drugs in preparation of the intestine it was only logical for the surgeons to turn to the newer antibiotics in an effort to improve the situation even further. The effectiveness of many antibiotics has been studied extensively; personally I have concluded that thus far neomycin seems to be as effective as any agent. A great deal of laboratory evidence supports this contention and, up to the time of preparation of this paper, enteritis, owing to Micrococcus, and other complications which have been noted to occur during the use of other antibiotics have not developed when neomycin has been used. During the two-day period when the patient is being prepared, neomycin is administered in large doses so that the content of the colon is well filled with this agent. A completely sterile stool has rarely been realized but we do not find it to be essential. Certain of the anaerobic bacteria can still be cultured from the stool, but most of the pathogenic organisms present in the colon are eliminated. The use of antibiotics can be injudicious to the point of promiscuity, and caution in their use is advisable lest that mistake be made. We are well aware also that many bacteria are completely resistant to the earlier antibiotics, that is, penicillin and steptomycin. However, we have been so impressed with the reduction in morbidity and mortality rates since a logical, well-planned program employing the newer agents has been the rule that we are convinced that the advantages of the antibiotics far outnumber the disadvantages.

In earlier years anemia was the preoperative problem of many patients who had lesions in the colon. Large quantities of blood had been lost from the lesion and diarrhea and derangement in alimentation led to further degrees of anemia. We are of the opinion that there is no substitute for whole blood in such cases, and we use it freely whenever it is well indicated. It is one of the greatest advances at our disposal. In addition to this, many new types of fluid for intravenous use have become commonplace. There is no longer any excuse for a dehydrated patient. The proper electrolytes, as well as the fluid element, are important and can be supplied and also accurately measured. Vitamin products are refined to the point where they can be used in a very specific fashion, and the use of vitamins C and K has proved effectual in the treatment of patients undergoing surgical measures for lesions involving the colon.

Recent advances in the form of modifications of nasal tubes to be employed for decompression of the intestine have made these tubes a valuable adjunct. We are careful not to rely on nasal tubes alone for colon cases because the tubes are intended for use in problems related to the small bowel; we find them especially valuable, however, if obstruction is impending or if a potential obstruction gives evidence of developing into a real problem. Proper use of these tubes will serve as excellent prophylaxis against postoperative distention.

Adjuncts to Operative Care

The surgeon of today finds himself working in a far more ideal atmosphere than ever before. When a patient is properly prepared for operation, his chances of being conducted safely through an orderly, well-conceived and well-planned operation are excellent. We especially salute the anesthesiologists who have developed their field so extensively of late. The well-controlled, balanced anesthesia, which employs carefully selected agents whenever they are in-

dicated, has changed the operation on the colon from a hurried, urgent, almost desperate maneuver into a casual, deliberate, prolonged (if necessary) and actually an exceedingly safe operation. The many supportive measures have become part and parcel of the anesthesiologist's routine so that the surgeon may devote all of his time and energy to the progress of the operation and need not interrupt his train of thought during operation to concern himself with supportive measures only.

Postoperative Care

The advances in care of the patient after operation have been almost unlimited in recent years, and the refinements in technic and products have afforded the surgeon who has studied them carefully, considerable aid during the postoperative period.

Trends in Surgical Treatment for Lesions of the Colon

The vermiform appendix is apt to be overlooked, but more and more frequently patients are being seen who have undergone appendectomy only to learn a week or two later that the pathologist has discovered a carcinoma of the appendix. In earlier years the surgeon might be tempted to follow the "watch and see" program, since radical removal of the right part of the colon was fraught with enough danger that he would be reluctant to undertake such an operation without real evidence of further malignant disease. Now, however, the risk is so extremely low that we do not hesitate to proceed at once with radical right hemicolectomy and we find that this procedure offers, when necessary, the opportunity for wide removal of contiguous tissue and lymphatic channels. Carcinoma of the appendix is still a rare lesion but one which must not be forgotten in discussion of lesions of the colon.

For tumors of the right portion of the colon itself, one-stage radical removal, completed immediately by means of an ileocolostomy, has become almost standard procedure in all clinics. The multiple-stage operation in this situation is now almost unheard of, whereas in earlier years it was all the surgeon had to offer. Resectability rates have risen steadily so that at present, even for malignant disease, an average rate would be well over 80 per cent. This is a distinct advance and means that the surgeons have been emboldened to proceed in a situation which earlier might have resulted in mere laparotomy and biopsy because of the risks involved.

Hospital mortality rates might be expected to rise steadily also with this much bolder and more aggressive program, but a check of the reports from most clinics today reveals that 3 per cent or less is a common figure quoted in this regard. Palliative resections are undertaken much more frequently because of the afore-mentioned tremendous advances that have been made. This will reflect itself in the survival studies because if a certain amount of a malignant lesion must, of necessity, be left behind and if a much bolder program is going to become the rule, prolonged survival rates may be modified by that very change. However, even in the face of all this, the conventional five-year-survival rates at the present time are well over 60 per cent.

Formerly treatment of lesions in the transverse colon, splenic flexure and descending colon resulted in relatively short survival periods. Great advancement has been made in this respect. Whereas only a limited amount of bowel and mesentery could be removed by means of the multiple-stage operation because the ends of colon must of necessity be made to reach to the skin level, now a much more radical removal of bowel and mesentery is the rule, and, actually, once the mobilization has been accomplished, the immediate anastomosis is far easier to accomplish because the transverse colon is being joined to the lower portion of the sigmoid and the surgeon is working well down in the wound rather than up under the diaphragm or in some other inaccessible position. The results of this much wider removal will certainly be reflected in a better survival record.

In the sigmoid colon, the region where the old Mikulicz operation and its many variations held sway for so many years, radical resection with immediate anastomosis is now an acceptable procedure. This proves to be a region where a one-stage

operation can be used just as well as in the right portion of the colon, and of late it has become the standard procedure. The obvious suggestion is that if hemicolectomy works so well on the right side, why not extend the operation into a radical hemicolectomy on the left also? A glance at statistics from earlier years shows that the left portion of the colon ordinarily was associated with only a 35 per cent five-year-survival average after resection for malignant disease. This is understandable when we reflect on the limited operation formerly done. Many authorities at present are arguing for standard hemicolectomies even for small carcinomatous lesions of the sigmoid, and the reports of the five-year-survival and ten-year-survival rates will be studied by all surgeons with great interest.

The rectosigmoid is no longer the subject of controversy that it was shortly after World War II. Many authorities have proved that if the rectum is mobilized completely and if a long segment of normal bowel can be removed from below the malignant lesion, the rectum itself can still be preserved and an end-to-end anastomosis carried out. No longer is this operation being extended to such a low level that early local recurrence is common. Control of the sphincter remains normal and excellent results have been the rule, not only as interpreted in hospital mortality rates but also in the survival statistics. Even in centers where radical sacrifice of the anus formerly was mandatory for any lesion which could not be treated by the old Mikulicz operation, we now witness proper usage of the low anterior resection with anastomosis.

In carcinoma of the rectum itself, however, it has been learned that such an operation must be applied only after careful thought. Studies of recurrence have shown that if the lesion is 10 cm. or less from the anus, the employment of any operation preserving the rectal sphincter will be followed by a relatively high rate of recurrence. In elderly patients, however, and in certain situations, especially palliative operations in selected instances, this operation may be justified. One must remember that the rectum inherently has a much worse type of carcinoma than the bowel located somewhat higher up in the abdomen and, whatever operation is attempted, the final results may be disappointing. We are agreed that the Miles combined abdominoperineal resection is still the operation of choice in the majority of cases of carcinoma of the rectum. The "pull-through" types of operations should never be substituted for the combined procedure but may well be substituted for a low anterior resection in certain instances. In those few cases a little more bowel may be removed below the carcinoma but the degree of control of the sphincter realized later by the patient may be subject to a great deal of question. At the present time the decision must rest with the experience and judgment of the surgeon.

Pre-existing Lesions

With the great enthusiasm recently exhibited for education of the public concerning cancer, physicians and surgeons have increased their efforts to do more for the populace as a whole. They have renewed their interest in precancerous lesions or lesions which might be treated at an early interval in a further effort to spare the patients the dire consequence of neglected lesions. An example of such a condition is chronic ulcerative colitis. It has been known for years that cancer may be engrafted on a change of that type, but it is only recently that we have revised our own thinking to the point where we agree that cancer may develop in perhaps 12 per cent or more of these patients. We have revised our thinking because we have operated in recent years for other indications in cases of ulcerative colitis and occasionally we have been surprised to find that, in addition to the stated indication, the specimen actually reveals an unsuspected cancer. Worse than this, the nature of these cancers is such that their high-grade tendencies make many of them inoperable by the time that the internist and surgeon have both finally become aware of their existence.

The multiple-stage operation, common in the past for ulcerative colitis, has given way to a standard two-stage removal of the colon. Instead of establishing an ileostomy and removing the colon piecemeal in multi-

ple operations, we now resect all of the abdominal portion of the colon down to the rectosigmoid level and establish the ileostomy at the same time. Whether or not a skin graft is applied to the ileostomy or the newer mucosal graft technic is used will remain a matter of personal choice. Later the rectum is removed at a separate operation. Many surgeons have been stimulated to take the entire colon out in one operation, but in some of the depleted, poor-risk patients such extensive surgical measures may not be warranted. In a small series of our patients the one-stage operation worked very nicely and perhaps it can be extended to more and more of these people. Ileostomy alone is no treatment for this condition. The disease is in the colon and the sooner we get the colon out, the better it will be for the patient. We are fully aware that we are substituting an ileostomy for the condition that the patient originally had, and we do not wish to treat people surgically unnecessarily. However, when certain indications exist, by employing the recent advances made available to us, we are of the opinion that we can bring more of these patients through operation safely and with far less morbidity.

A second lesion of "precancerous" nature is the polyp of the colon. We have no quarrel with those who would do a local transcolonic excision of a well-pedunculated, benign, isolated polyp, and we do it ourselves frequently. However, if more than one polyp is present, if it is a recurrent type of lesion and especially if the polyp is malignant, we now argue for a formal resection of the intestine. This means that we are now taking out long segments of colon for two or three polyps and are doing it with a very low risk. Not only are we getting rid of the lesions and settling the issue concerning malignancy in the same step, but, even more important, we are getting rid of that part of the colon where polyps tend to develop followed later by carcinomatous lesions. We consider this to be a decided step forward and are not hesitating to do rather radical resections in situations where, in earlier years, multiple local removals might have been accepted practice.

Multiple polyposis of the familial type is a different condition. Patients having this condition will die of carcinoma of the colon unless the colon is removed. The difficulty in earlier years lay in the fact that the children knew what happened to the parents and other relatives who had one colonic stoma or more followed by a variety of operations and by the development of an inoperable carcinoma if the delay between stages was too great. Later in life these children could not bring themselves to go through that same sequence of events and, naturally, they avoided surgical intervention until it was hopelessly too late. We now have something much better to offer such people. We have removed the terminal portion of the ileum and all of the abdominal part of the colon down to the proctoscopic level low in the sigmoid in a fairly large number of patients. We complete the operation in one stage as an end-to-end ileosigmoidostomy. This can be done rather easily and with low risk. Soon after the patient's convalescence is complete, the proctologist fulgurates the remaining polyps. With an end-to-end anastomosis he knows exactly where the remaining portion of colon starts and ends and he can control the distal segment completely. Even after all visible polyps have been destroyed the patient is requested to return at stated intervals for the rest of his life since further polyps may form. As long as the proctologist can stay ahead of the disease, all goes well. These patients are easy to trace and are almost never "lost to follow-up." They know what has happened to other members of their families who have not followed directions, and they form a very gratifying series. We are fully aware that carcinoma of the rectum may develop, and if it is already present we remove the entire colon, leaving the patient with an ileostomy. However, we are also fully aware of the disagreeable state brought on by ileostomy and, if at all feasible, we try to preserve the rectum. Should carcinoma develop later in the preserved part of the rectum, combined abdominoperineal resection is indicated at once, but in our experience this complication has rarely developed.

A monthly news summary from the national capital by the Washington Office of the A.M.A.

Within a few months there will be under way the first comprehensive survey ever to be made of the nation's mental health problems. The study will attempt to measure the extent of mental illness, to judge the progress and lack of progress in research, and to estimate the additional hospitals and clinics and trained personnel needed before a start can be made toward a solution.

A newly-formed Joint Commission on Mental Illness and Health already has begun preliminary work on the survey. The all-out effort will be initiated—possibly before the first of the year—after the Commission has received the formal approval of the National Mental Health Advisory Council of U. S. Public Health Service and the Surgeon General. Once this endorsement has been given, $250,000 in U. S. funds will be available to help with the first year's operations. Another million dollars is to be supplied over the following two years.

Originally, the Joint Commission was formed by the American Medical Association's Council on Mental Health and the American Psychiatric Association. Later other associations joined in, including the American Association of Psychiatric Social Workers, the American Hospital Association, the American Nurses Association, the National League of Nursing, the American Psychological Association and the National Education Association.

A nationwide survey has been the objective of these associations for more than a year. Substance was added to the idea this year when Congress approved the $1,250,000 fund, to be used over three years, for a comprehensive study. The law specifies that the investigation be conducted by non-governmental bodies; to fully qualify, the Joint Commission has been legally incorporated.

At hearings before Congressional committees early this year psychiatrists and others outlined the complex problem they are facing.

The care of mental patients is one of the great financial burdens of the states; rate of cure and rehabilitation is so low that institutions are being filled as fast as they can be constructed; half the hospital beds are occupied by mental patients and their care costs more than a billion dollars a year in tax funds.

There are not enough psychiatrists trained to administer state programs or even all the large hospitals; competition for the top men in this field has been compared to the proselyting of football players and coaches.

Many of the leading psychiatrists complain that too much attention is being paid to constructing hospitals and not enough to research, which might develop treatments that would keep many patients out of institutions, and bring about the rehabilitation of hundreds of thousands of others now hospitalized.

In testifying before a House committee early this year, Dr. Leo H. Bartemeier, representing the A.M.A., argued for federal help in conducting the survey. He told the Committee: "For several years we in the profession of pschiatry have been aware of the critical need for a survey and evaluation of our facilities and programs for the diagnosis, treatment and care of the mentally ill and retarded. While the problems of mental illness appear to grow in almost geometric proportion, we find ourselves without a comprehensive, up-to-date, integrated body of knowledge in spite of the fact that many worthwhile surveys and studies in this field have been made. It is only with such complete knowledge that our present and future direction and programs can be properly planned."

Notes

Before it prepares a report on the narcotic problem, the Senate subcommittee will have held hearings in most parts of the country. Many local addiction problems have been described. At the New York hearing, the subcommittee was urged to recommend a system of clinics, where the addict legally could obtain narcotics at reasonable cost, thereby defeating the rackets.

Although states either may take U. S. grants to buy Salk vaccine or the vaccine itself, most of them are taking the money.

Veterans Administration has set up a seventh area medical office in Columbus, Ohio, a move that it believes eventually will provide better service at less cost.

Almost nine million dollars will be spent next year on health work in North, South and Central America by international bodies, such as World Health Organization. One project is the starting in Mexico of a four-year malaria eradication program.

The Navy has set up a program for training Waves as nurses; they will be obligated for a year's active duty for each year of training.

Bureau of Internal Revenue has summarized deductible and non-deductible medical expenses for income tax purposes; the listings combine new interpretations with a clarification of old rulings.

ABSTRACT OF MINUTES*
HOUSE OF DELEGATES
of the
COLORADO STATE MEDICAL SOCIETY

85th Annual Session
September 20, 21, 22, 23, 1955

Shirley-Savoy Hotel
Denver, Colorado

FIRST MEETING
Tuesday, September 20, 1955

Vice Speaker William B. Condon of Denver called the House to order at 10 a.m. and recognized Dr. John L. McDonald, Chairman of the Committee on Constitution, By-Laws and Credentials.

Dr. McDonald presented the Committee's report as printed in the House of Delegates Handbook and amended it by recommending the seating of Dr. D. R. Barglow, as alternate from Las Animas County Medical Society, and Dr. Richard H. McIlroy, as alternate in place of Dr. Clifford F. Bramer, of Pueblo County.

Seventy-two accredited delegates (more than a quorum) answered the original roll call.

On motion, the reports of the Credentials Committee were adopted.

Vice Speaker Condon introduced Speaker John A. Weaver, Jr., Greeley, who welcomed new delegates, commended President Newman, the Board of Trustees, Executive Secretary Sethman and the Executive Office Staff, for resolving the many problems which confronted them one year ago, with a minimum of friction and a maximum of harmony and efficiency, stressed the importance of problems which must be acted upon during this Session, and briefly outlined procedural matters.

President Newman introduced Earl L. Malone, M.D., Roswell, New Mexico, President of the New Mexico State Medical Society, who was visiting this Annual Session.

On motion regularly seconded and carried without dissent, minutes of the Interim Session of the House, held February 15 and 16, 1955, were adopted, without correction, as published in the April, 1955, issue of the Rocky Mountain Medical Journal.

(Speaker Weaver and Vice Speaker Condon alternated in presiding over the remainder of the sessions. Secretary Sethman conducted a recheck of the Roll Call to list late arrivals.)

Reports of Board of Trustees

President Samuel P. Newman, Denver, presented the Annual Report of the Board of Trustees as printed in the Handbook. He also submitted a mimeographed supplemental report of the Board transmitting a summary of the Annual Audit, and called upon Dr. John S. Bouslog, Chairman of the Revision Subcommittee of the Code of Cooperation Committee, to present the mimeographed supplemental report for the Board of Trustees.

There was no discussion of these reports and supplements and they were all referred by Speaker Weaver to the Reference Committee on Board of Trustees and Executive Office.

When he was informed that one of the members of the Reference Committee on Board of Trustees and Executive Office, Rex L. Murphy, of Denver, would not be present, Speaker Weaver appointed in his place Samuel B. Childs, of Denver.

Speaker Weaver invited all members of the Society, as well as all delegates, to appear before any reference committee to present their views with regard to reports being discussed by the reference committee. The following printed reports were received and referred to Reference Committees: Report of the Board of Councilors, and Report of the Board of Supervisors.

Report of President

President Newman addressed the House as follows:

This year I come to you with a quite light heart, the reason being it has been a good year. It has been a good year because the members of this Society have worked together, as our Speaker has already told you. I want personally to thank all of the members of this Society who have served on committees this year because much has come out of those committees, because the members have been so willing to work. There have been on occasions assignments made to men that were difficult to accept because they entailed unpleasant duties. I am pleased to report to you that on those occasions I have not been turned down because your members were so willing to carry their load.

I cannot refrain from mentioning at this moment also one other thing of a personal nature: When one holds this job as the President he is expected to give a considerable amount of time. I am fortunate in having a partner who has carried a good deal of the load in our office from a private, personal business point of view and I simply wish to thank him in your presence for having been so kind while I tried to work with you. I also want to thank the members of our Executive Office. They have served well this year and the business has gone along good. We have had many problems come before this Society. We haven't solved all of them. I am going to mention a few of them that will probably be carried over into the next year and probably the next year thereafter and still on, because some of them will require a long time to solve; and then we will think they are solved and somebody else will change the tune again.

One is accreditation of hospitals. You know that your Society sent a resolution to the American Medical Association, and it had a great deal to do with the American Medical Association studying this problem nationally. One of our own members, Dr. George Unfug, has been put on the Special Committee to study that problem. If you have any information that would be helpful to him you are urged to give it to him.

One other thing that would be very important for you to do is to get all of the directives and pamphlets and various kinds of literature on the Commission on Hospital Accreditation and familiarize yourselves with those. I am sure that you will find that too frequently there have been interpretations placed upon those directives that are not quite in keeping with their intent. I am sure that if we will all work together we will be much happier in our hospital work insofar as accreditation work in our hospitals is concerned.

There is another problem which I am sure will take a long time to solve, and that is the question of labor and medicine. The American Federation of Labor and CIO have joined in their study of medical services and medical care. They have put out a pamphlet that states their thinking rather clearly. They speak of freedom of choice of physicians, but I would warn you to be cautious of what their definition of freedom of choice of physicians is as compared to yours. They mean free choice of physicians out of a small panel. They do not mean free choice of physicians from anyone of your group. So

*Condensed from the shorthand and sound recorded record of H. E. Dennis, Certified Shorthand Reporter. Reports referred to but not reproduced herein were distributed to all members of the House of Delegates in advance of the Annual Session in the printed "House of Delegates Handbook" or were distributed to all members of the House in mimeographed form. Copies of all such reports are on file in the Executive Office of the Society, and with the Secretary of each component society, available for study by any member of the Society.

when you go to studying it be cautious about it. This is a problem to be studied further by your State Medical Society Committees.

Your Board of Trustees saw fit to appoint a liaison committee of top-level variety to meet with representatives from the same level of the Hospital Association to discuss mutual problems. This committee is not one to replace the old standing committee of this Society; it is a liaison committee that has no more power than simply to discuss these problems. I believe it is an important committee, because we must get along with the hospitals and we must let them know what we believe should be Medicine and remind them what we think is hospital care; and by our working together we can keep them well-informed of our feelings. In some areas hospitals are entering into the field of medicine more and more. One of our neighboring states has even gone so far as to give hospital privileges to one of the local physicians who was a trained anesthetist; but they gave him privileges to do everything but anesthesia! They told him he could do anesthesia only if he would work on a salary. Now we get along very well with the hospitals in our state because we have some pretty good men to deal with. But we must continue to get along with them, and ever watch as to our own rights.

The nursing shortage is a problem that I am sure we should get involved in, too. The nursing board sets up certain regulations governing the qualifications of nurses who may be licensed. That is proper. We do the same thing as far as medicine is concerned. But sometimes it seems that some of these regulations may be a part of the cause of our nursing shortage. As an example, in recent weeks one of the hospitals in Denver had four girls apply for jobs in the surgical section of the institution. The institution felt that their qualifications were very adequate to work in the operating room. They were advised to get their license and come out and go to work. They went down to check on getting a license, and three of these girls lacked some psychiatry. They were advised by the nursing board that they should go out to Fitzsimons Hospital and get three months of psychiatry. Now this is a problem that, I am sure, in general, we should discuss with the nurses and see wherein we may better get nursing care in our institutions.

Another problem is the fee schedule with the Industrial Commission. I believe that this is probably one of the most commendable jobs that has been done this year. To be sure it has not been perfect. There has been some criticism of a portion of this fee schedule. I have been called, and I am sure that next year the President will be called on occasions, on things about which someone is unhappy. But he, as I did, I am sure, will welcome those calls because it is up to us to tell those individuals what they can do about them. Men who have called me have been advised to come to this House of Delegates, go to the reference committees and discuss their views and find out wherein they may be helpful in trying to solve the problems. But I am most proud of the Fee Schedule Committee because I believe it has done a good job. I hope some improvement can be made, but if it can't, it is certainly much better than it used to be.

You have already heard Dr. John Bouslog discuss the Code of Cooperation. That has been a rather difficult problem this particular year, but we have found the newspapers, the television and radio men, most cooperative in sitting down and discussing these matters. I believe we will understand each other better after this work has been completed by Dr. Bouslog's committee.

The last question I wish to mention is the Medical School. As you know the Medical School has wanted to have a private pavilion, or to admit private patients to the Colorado General Hospital. Your Board of Trustees has met with the Board of Regents and discussed this matter. We had a liaison committe that met with the liaison committee of the Board of Regents that studied the subject rather carefully, particularly the matter of a private pavilion or private admission of patients, and, secondly, publicity emanating from that institution. Much came out of the discussions in these liaison committees. One agreement did come out of it and that was that it was felt private practice privileges to the full-time faculty would be desirable. You may remember that your House of Delegates in 1950 went on record as allowing private practice privileges to the full-time faculty on a referral basis. Under this new discussion referral was not mentioned. The important difference between the two groups today is that it has not yet been determined where private practice privileges shall be. The Board of Regents has asked for a top-level committee from your Board of Trustees and other members of the Society to meet with them after this meeting, if you so desire, to see in what manner this private practice privilege may be worked out. So that is one of the problems, in part, that you must meet here. That is the question of whether or not you want such a committee appointed and to continue on with the studies.

Dr. Cyrus Anderson and I went to Chicago day before yesterday and met with a subcommittee of the Council on Medical Service of the American Medical Association, which is studying this problem of tax-supported medical schools and private patient care. The states of Georgia, Mississippi and Oregon each had four representatives at this meeting. They are rather vehement in their views of what is going on in their communities. I plan to appear before the reference committee that is going to study this matter, and at that time I will present to them the things that Dr. Anderson and I learned in Chicago. I will not bother you with details here, for lack of time. But it is a problem we must solve, because all of us recognize that our full-time faculty men are inadequately paid and some means must be sought and found so that the philosophy of your profession may be maintained and that they may be adequately paid. One solution that has been offered is private practice in the private hospitals in the City and County of Denver. The private hospitals have stated that they have approximately 1,871 beds within 15 minutes of the University of Colorado School of Medicine which they will make available to the full-time faculty on the same basis as any other private physician; that they will make staff positions for them comparable to the other men in private practice. Secondly, they have offered to cooperate with the Medical School in trying to carry out a teaching program to meet the desire of the full-time faculty of the use of private patients in their teaching. I think this is one possible solution, at least on a temporary basis, and is worthy of consideration.

In closing, again I want to thank the members of this Society for all of the many things they have done when I have asked them to work this year. It has been truly a pleasure. The Board has worked hard. It has been harmonious. It has been a pleasant year and, to me, a good year. I thank you!

Speaker Weaver referred Dr. Newman's Report to the Reference Committee on Board of Trustees and Executive Office.

Report of President-elect

President-Elect Robert T. Porter, Greeley, addressed the House as follows:

I want to speak about just one subject which I think is important to our Society and which is quite dear to my heart and which I think is of importance, so important that I think it should be emphasized more than it is in the Handbook.

I appeared before the House at the last Annual Session to discuss the need for a building for the State Medical Society. I beg your indulgence to discuss it again. The need for more space is emphasized by the Report of the Executive Secretary in the Handbook. The Building Committee has previously reported concerning the needs and the possibilities. After six years of association with the operation of this organization I am positive that the greatest forward step that this Society could take would be to provide for itself, for the present and for some time in the future, a building with adequate space for offices and for new office equipment as needed, committee rooms, and sufficient parking. Over a period of years this would be a financial saving to the Society and its members. The money is available to build such a building. I believe the efficiency of a new building would be superior to and less expensive than any old building which we could buy and remodel. Therefore I urge you to authorize the Board of Trustees to continue to investigate this problem, with authorization to build if a suitable place can be obtained at a total cost of not more than $55,000 to $60,000, if the site must be purchased, or $50,000 if the land is secured on a $1 a year, long-term lease.

You have already authorized these studies in the past, but it is important. We are more and more short of space. We have to hold our committee meetings in hotels. We have inadequate parking and other facilities. We are honestly confident that we can do a much better job for this Society if it is given adequate facilities.

The personal report of President-Elect Robert T. Porter was referred to the Reference Committee on Board of Trustees and Executive Office by Speaker Weaver. No other member of the Board of Trustees, the Board of Councilors, or the Board of Supervisors submitted a personal report.

ACH

(you probably know every answer!)

Q. **Which is today's most widely prescribed broad-spectrum antibiotic?**

A. **ACHROMYCIN — it's first by many thousands of prescriptions.**

Q. **What are some of the advantages of ACHROMYCIN?**

A. **Wide spectrum of effectiveness.**
Rapid diffusion and penetration.
Negligible side effects.

Q. **Exactly how broad is the spectrum of ACHROMYCIN?**

A. **It has proved effective against a wide variety of infections, caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa.**

Q. **In what way are ACHROMYCIN Capsules advantageous?**

A. **For rapid and complete absorption they are dry-filled, sealed capsules (a Lederle exclusive!) No oils, no paste...tamperproof.**

Q. **Who makes ACHROMYCIN?**

A. **It is produced — every gram — under rigid quality control in Lederle's own laboratories and is available only under the Lederle label.**

CHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle

Lederle

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

Constitution Amended

Printed reports were received and referred to Reference Committees as follows: Report of the Delegates to the American Medical Association, Report of Foundation Advocate, Report of the Executive Secretary, and the second report of the Committee on Constitution, By-Laws and Credentials. As part of the latter, Chairman John L. McDonald reported the two related amendments to the Society's Constitution, proposed and given approvel in the last Annual Session, as now ready for final approval. These were printed on page 26 in the Handbook:

> Amend Article IV Section 1 of the Constitution by deleting the words "Emeritus Members."
>
> Amend Article IV of the Constitution further by deleting Section 4 and renumbering the subsequent sections.

On motion of Dr. McDonald, regularly seconded, there being no discussion, and the motion being carried without dissent, the Constitution was so amended.

Dr. McDonald further referred to page 26 and all of pages 27 and 28, and the upper two-thirds of page 29 in the Handbook, these being By-Law amendments reprinted from the February proceedings and all subject to passage by the House at this time. He moved adoption of these amendments.

Executive Secretary Sethman pointed out a typographical error in the reprinting at the middle of page 27 of the Handbook, relating to the Board of Councilors, the sentence reading: "The Board shall annually elect from its membership a Chairman and a Secretary." The word "Secretary" was a misprint, and should read: "Vice Chairman," because the By-Laws already provided for a Secretary to that Board.

Chairman McDonald accepted the correction and moved adoption of the amendments to the By-Laws as corrected. The motion was seconded, there was no discussion, and it carried without dissent; whereupon Vice Speaker Condon declared the Constitution and By-Laws of this Society changed to the extent shown above.

Chairman McDonald submitted a proposed change in the Standing Rules of the House of Delegates, concerning revision of existing Councilor Districts, directed attention of the delegates to the proposals as set forth at pages 32 and 33 of the Handbook, and called upon Mr. Sethman to exhibit and explain maps which, at the direction of the Committee, had been prepared for elucidation of the proposed changes, for demonstration to the House.

A motion to adopt the proposed change in the standing rules was seconded and a brief discussion ensued. Chairman McDonald consented to accept a motion by Dr. Frank B. McGlone to refer the proposal concerning redistricting to the Reference Committee on Constitution, By-Laws and Credentials, and this motion carried without dissent.

The following printed reports were referred to Reference Committees: Committee on Health Education, Committee on Library and Medical Literature, Committee on Medical Education and Hospitals, Committee on Medical Service, Subcommittee on Blood Banks, Subcommittee on Distribution of Physicians, Subcommittee on Emergency Medical Service, Subcommittee on Hospital-Professional Relations, Subcommittee on Indigent Medical Services, and Subcommittee on Intraprofessional Insurance Problems.

Chairman Ralph M. Stuck presented a supplemental report, by way of communications which he read, addressed to him September 13, 1955, by Sam N. Beery, Commissioner of Insurance of the State of Colorado, and directed to the American College of Physicians at Wilmington, Delaware, under the same date, and the American College of Surgeons at 40 East Erie Street, Chicago 11, Illinois, stating the attention of the insurance department had been directed to the fact that the American College of Surgeons and the American College of Physicians have offered the doctors of the State of Colorado coverage in insurance companies not licensed to do business in Colorado.

Dr. Stuck's supplemental report was referred to the Reference Committee on Professional Relations.

Additional printed reports received and referred were: Subcommittee on Prepayment Services, Subcommittee on Veterans Medical Care, Medicolegal Committee, and the Report of the Nominating Committee. Dr. J. L. McDonald stated Chairman Edgar E. Elliff had asked him to announce there would be a supplemental report of the Nominating Committee and asked all members of the Committee to assemble for an important meeting after this meeting of the House of Delegates.

The following printed reports were then referred to Reference Committees: Report of General Committee on Public Health, Subcommittee on Cancer Control, Subcommittee on Crippled Children, Subcommittee on Geriatrics, Subcommittee on Industrial Health, Subcommittee on Maternal and Child Health, Subcommittee on Mental Health, Subcommittee on Rehabilitation, Subcommittee on Rocky Mountain Cancer Committee on Sanitation, Subcommittee on Tuberculosis Control, Public Policy Committees on Legislation, Publicity, Weekly Health Column and Health Articles, and the Public Policy Committee as a whole.

Public Policy Supplement

Chairman Milligan submitted a supplemental report for the Public Policy Committee to report that the problem of the United Mine Workers with doctors of Trinidad and the hospital there had been referred to the newly-activated United Mine Workers Advisory Committee; and, second, he gave a progress report on the uniform health insurance claims forms project, a project with the Health and Insurance Council of the AMA.

He moved the inclusion of his supplemental report, the motion was seconded, there was no discussion, and it carried without dissent, and the supplemental report was referred to the Committee on Legislation and Public Relations.

Executive Secretary Sethman called attention to a typographical error in the first paragraph of the report of the Committee on Rocky Mountain Medical Conference, the printer having accidentally omitted a whole line of type. The last sentence should read:

> "The only respect in which the 1955 Conference failed was in the matter of Colorado's attendance, which fell far below expectations and far below the average Colorado attendance at previous meetings of the Five State Conference outside of Denver."

The following printed reports, as corrected, were referred to Reference Committees: Committee on Rocky Mountain Medical Conference, Committee on Scientific Program, Subcommittee on Entertainment, Advisory Committee to the Auxiliary, Advisory Committee to United Mine Worker Welfare and Retirement Fund.

Chairman William H. Halley submitted a supplemental report, which had been mimeographed for distribution to the House of Delegates. Dr. Halley briefly summarized this report, and thereupon the Vice Speaker referred it to the Reference Committee on Legislation and Public Relations. The complete report follows:

Report of United Mine Workers Advisory Committee

The object of this Committee's meeting was to continue the "review of the relations existing between the UMW Welfare and Retirement Fund and the Colorado State Medical Society." At the February, 1955, session of the Colorado State Medical Society a resolution was adopted "to reconstitute, immediately, the Advisory Committee of the Colorado State Medical Society to the UMW Welfare and Retirement Fund." A further quotation from this resolution is important. "We are of the unanimous opinion that the freedom of choice of physicians is a fundamental principle to be preserved in American medicine. We believe that the medical profession should at this time re-examine this concept and if we no longer believe it to be tenable it should be abandoned. If we do believe in this principle we should be willing to live, or as the case may be, die by it. We are aware of increasing domination of practitioners of medicine from many quarters resulting in some degree of abandonment of this principle, and therefore believe that the organized profession should do everything possible to stimulate its members to preserve this right for the American people." In analyzing the concept of free choice of physician, it is obvious that the individual who, together with the organization which pays for the services of a physician, should have a voice in the selection of such physician. The Committee believes in the principle of freedom of choice of physician.

In May, 1954, a directive was issued by Dr. William A. Dorsey, Area Director of the UMW Welfare and Retirement Fund, which limited surgical treatment to surgeons who were:

(a) Certified by the appropriate Specialty Board.
(b) Fellows of the American College of Surgeons.
(c) Eligible for certification or fellowship.

Medical treatment for hospitalized patients would be reimbursed by the Fund when:

(a) The admitting physician is certified or is eligible for certification by an appropriate Specialty Board.

(b) The admitting physician not so qualified but had consultation with a certified physician prior to admission to hospital.

Emergencies and obstetrics were excepted from this ruling.

Dr. Dorsey stated that:

(1) Provisions were made for physicians who do not meet the above criteria, but with whom the Fund has had sufficient experience of a kind to assure the Fund of a high quality of medical care, to manage their patients without restriction.

(2) That there was no immediate probability that the directive would be rescinded or modified, but it was not their intention to be adamant and flatly refuse to modify the directive, but rather to indicate that any modification should be based on thorough consideration of all the problems involved.

(3) That during the fifteen months during which the directive has been in force, there has been a reduction in expense to the Fund of from 33% to 50% in certain areas under his jurisdiction, some of these in Colorado.

(4) That, during this time, medical and surgical services have been adequate and have improved in quality.

(5) That general practitioners were still being employed in certain areas. Actually, general practitioners are being used in all areas, although most of them practice under the restrictions enumerated above. More than half of all hospitalized Fund beneficiaries are under the care of general practitioners.

(6) That the Blue Shield Preferred Plan was acceptable as a fee schedule.

Regarding paragraphs 3 and 4, immediately above, the Committee has requested but has not yet received, evidence to substantiate these statements.

The Committee calls attention to the following resolution adopted by the House of Delegates of the American Medical Association in Atlantic City last June, this resolution having been written by a Reference Committee of the House as a substitute for four resolutions on the subject that had been introduced by several State delegations:

> "RESOLVED, That the House of Delegates of the American Medical Association expresses its disapproval of that portion of the directive issued by the executive medical officers of the U.M.W.A. Welfare and Retirement Fund which requires consultation by a specialist before admission to a hospital of all beneficiaries of this program who are treated by physicians other than those approved by the U.M.W.A. Welfare and Retirement Fund as specialists; and be it further
>
> "RESOLVED, That all other controversial matters arising between the U.M.W.A. Welfare and Retirement Fund and the participating physicians which cannot be reconciled at the local or state level shall be promptly referred to the Committee on Medical Care for Industrial Workers of the Council on Medical Service and the Council on Industrial Health of the American Medical Association."

The Committe recommends that:

(1) The Committee be designated "The Liaison Committee of the Colorado State Medical Society to the UMW Welfare and Retirement Fund," and be composed of eight members.

(2) That the Committee shall receive, or be apprised of, complaints or suggestions from any physician in matters relating to the UMW Fund or from the Area Director of the Fund. These communications to be filed in the Executive Office for the information of the proper Officers and Boards of the State Society.

(3) That the Committee, at its discretion, may request a conference with the Area Director of the UMW Fund, and that the Area Director may, at any time, request a conference with the Committee.

(4) That when an adequate fee has been paid for a surgical procedure, further charges for postoperative visits be eliminated. Complicated cases to be adjudicated between the surgeon and the Fund Director.

(5) That the Committee be continued for one year.

Vice Speaker Condon referred the report to the Reference Committee on Legislation and Public Relations.

The report of the Automotive Safety Committee was received as printed, and referred to the same Reference Committee.

Blue Shield Fee Schedule Report

Chairman Frank B. McGlone of the Blue Shield Fee Schedule Advisory Committee submitted a typewritten report which was referred to the Reference Committee on Legislation and Public Relations, as follows:

We did not have the report in the Handbook because very little business had been accomplished and most of the policies were to be made at the meeting which was held last night, and the entire report will be in the form of the report given by me at this time:

During the past year, between 1954 and 1955, there have been two meetings of the full Committee and two meetings of the Executive Committee. The Committee has considered each written request received and the minutes of the meetings will be submitted to the Reference Committee as a part of this report. All of the changes in the fee schedules up to August 5, 1955, have been mailed to the members of the Committee during the year.

The Committee this year has adopted the policy of referring most of the requests made by individual physicians to either the County Medical Society or the specialty group concerned with the particular problems. The proposal is then re-submitted to the Committee with the approval or disapproval of the component society or specialty group.

The Committee discussed the problem related to Blue Shield benefits to Old Age Pensioners at a reduced rate. This proposal was dismissed last year and presented to the House of Delegates and acted upon favorably, but there has been no action taken on this by the Society during the past year. At the meeting of the House of Delegates last year it was also decided that the Blue Shield Fee Schedule Advisory Committee would be a rotating committee. No action was taken on this during the past year and it is recommended that during the coming year the Board of Trustees take action upon this matter.

The Committee met this year the night before the opening of the Midwinter Clinics and the night before the beginning of the State Society meeting. The Committee recommends that these dates become regular dates for the meetings of this Committee each year.

A plan was proposed by the Blue Shield Board for giving a $25 health examination certificate for $10 to subscribers (adult) who have been members of Blue Shield for three years or more. Preliminary estimates of the cost of such program indicate that such a trial would present no important financial problem to the plan. This proposal would provide for the first time a preventive measure sponsored by health insurance plan. The proposal should also create good public relations and be a reward to subscribers who have been in the plan for three years or more. This proposal was approved by your Committee for one thirty-day trial during one twelve-month period following which the proposal would be re-evaluated.

A second proposal of the Board of Trustees related to a home and office call benefit rider which was discussed. This rider would be offered as a

separate rider entirely on an indemnity basis to provide for home and office calls in a particular illness after the third office call. It is being offered merely to provide a vehicle to meet competition of private insurance carriers. It is anticipated that very few of these riders would be sold. The Committee voted to accept the rider as proposed. It was recognized, however, that the sale thereof would undoubtedly be very limited because of the high cost and relatively limited demand, but that it would be an important sales instrument and should be available upon demand.

The preferred plan benefit for assistant surgeons was discussed by the Committee. It was pointed out that the experience over the past years would indicate that the benefit in question was subject to utilization beyond its intended scope and that the abuses encountered constitute a financial hazard to the plan. Solution of this problem appeared to be beyond control under the present regulations. There was considerable discussion during which the Committee explored many explanations for the untoward utilization of the benefit and methods for controlling the situation which had been noted. The Committee voted to recommend that the Blue Shield plan conduct an intensive educational campaign over a period of six months in an effort to acquaint the participating physicians with the scope of the problem at hand in the hope that the assistant surgeon benefit would not have to be markedly altered or discontinued. The Committee also voted to appoint a subcommittee to continue to explore the possible actions which could be taken as a means of controlling the benefit without eliminating it if some important change should become necessary during the coming year. It was understood by the Committee that the question would be reconsidered at the meeting of the full Committee to be held during the Midwinter Clinics in 1956.

The Committee recommended that the Blue Shield Board contact the various Medical Societies and arrange dates for meetings with the staff of Colorado Medical Service, Inc. Such meetings would provide the services of the staff to discuss the plan at the level of the County Medical Societies.

The following printed reports were received and referred to Reference Committees: Committee on American Medical Education Foundation, Committee on Military Affairs, Committee on Physician-Nurse Relations, Medical Student Loan Fund Committee, Representatives to the Adult Education Council, and the Representative to Rocky Mountain Radio Council.

This concluded the presentation of annual reports.

There was no unfinished business remaining from previous sessions of the House. Speaker Weaver then declared he would entertain new business, such as resolutions, from any delegate.

Delegate H. M. Van der Schouw (Clear Creek) submitted the following resolution:

Resolution

WHEREAS, Much Compensation work is performed that does not need hospitalization; and

WHEREAS, Doctors are capable of knowing what they can do and are qualified to do; and

WHEREAS, The ruling by State Compensation on fees paid for x-rays is discriminating and unfair to the majority and favorable to the small minority;

BE IT THEREFORE RESOLVED, That the Colorado State Medical Society go on record as opposing this section of the State Compensation Insurance Fund Fee Schedule which provides for higher fees for a very few specifically named specialists.

(The original copy of this resolution was signed by twenty-eight physicians and surgeons from Lakewood, Wheat Ridge, Edgewater, Arvada, Idaho Springs, Evergreen, and Golden, Colorado.)

Speaker Weaver referred the resolution to the Committee on Public Relations.

Speaker Weaver asked for any other New Business.

President Newman addressed the House as follows:

"It seems to me that the Presidential Address is given at a rather inopportune time as far as this House is concerned. I would like to suggest that a reference committee at least consider changing the time of the Presidential Address to much earlier in the meeting so that the President may give a suggested planned program that he would like carried out during his administration. That would give this House some opportunity to further instruct him or to tell him to knock off certain portions of it. Now whether it would be called a Presidential-Elect Address, or what, I don't know; but I believe it is a thought worth considering because now the President talks when the meeting is all over with, and he may talk on philosophy or anything else. But I believe he should outline some of his thoughts for the coming year, since he has had a year's experience on the Board and in the activities in the year just preceding his taking office."

Speaker Weaver referred Dr. Newman's proposal to the Reference Committee on Constitution, By-Laws and Credentials.

There was no further New Business presented, Speaker Weaver called upon Secretary Sethman for announcements, following which Speaker Weaver declared the House of Delegates adjourned as such until two o'clock p.m., Wednesday, September 21, 1955.

SECOND MEETING
Wednesday, September 21, 1955

Speaker Weaver called the House to order at 2:00 p.m. No further Credentials Report was presented.

The Roll Call disclosed 73 accredited members of the House present, more than a quorum. Dr. Lawrence T. Brown, Denver, was seated as alternate for delegate Ralph M. Stuck. Dr. Walter E. Vest, Jr., Denver, previously seated delegate, was absent, and his alternate, Melvin A. Johnson, was seated in his place. In the absence of delegate Warren W. Tucker, Denver, his alternate, Marvin E. Johnson, was seated.

Fraternal Delegate From Mississippi

Speaker Weaver introduced B. B. O'Mara, M.D., of Biloxi, Mississippi, Past President of the Mississippi State Medical Association, fraternal delegate to the Colorado State Medical Society, who addressed the House briefly, extending greetings from his Society, expressing gratitude for the opportunity to attend this Annual Session, and inviting the Colorado Society to send a fraternal delegate to the meetings of the Mississippi Association, in Jackson, next year, and in Biloxi the following year.

Speaker Weaver suggested that the House recognize the fact Clemens F. Eakins, M.D., of Brush, Morgan County Medical Society, had been a member of the House of Delegates for 30 years. Dr. Eakins stood and was greeted by much applause.

Speaker Weaver declared, in the absence of objection, the reading of the Minutes of the First Meeting of the House would be dispensed with.

President Newman reported that the Board of Trustees had held an additional meeting since the First Meeting of the House and that after review and discussion of legal aspects the problem of the Medical Practice Act discussions between this Society and the Colorado Hospital Association had been re-referrd to the Committee on Public Policy for further study; that the Board felt presentation of the problem to this meeting of the House would be premature, and that the Committee on Public Policy would call upon the House at the Interim or Mid-winter session for further advice. It was determined that as this report was strictly informational it could be acted upon without the use of a reference committee and thereupon the House unanimously accepted this report of the Board of Trustees.

Chairman Leo W. Lloyd, Durango, presented a supplemental report of the Board of Councilors in two sections, the first section of which was by Speaker Weaver referred to the Reference Committee on Professional Relations and the second section to the Reference Committee on Con-

stitution and By-Laws and Credentials, as follows:

Supplemental Report of the Board of Councilors

(a) In the annual report of this Board presented to the House yesterday, we referred to appeals pending before the Board of Councilors from the decisions of two component societies, in each case involving a component society's rejection of an application for membership. One of these cases was concluded in a hearing yesterday and the Board of Councilors has directed the component society to elect the applicant to membership. The Board found no grounds for rejection of his application.

The Board of Councilors has under consideration another matter of vital importance to the Society. The recently re-constituted Advisory Committee to the United Mine Workers Welfare and Retirement Fund, of which Dr. William H. Halley is now the Chairman, has inaugurated an active program of work toward the solution of medical care problems to that Welfare Fund. In that connection Dr. Halley's committee submitted to the Board of Councilors a series of twelve pertinent questions related to the ethical status of current practices in the Trinidad area. The Board of Councilors has recognized that answers to these questions must be found, and this must be done promptly. Intensive work on this was begun by Dr. Halley's committee and by the Society's Legal Counsel in advance of actual consideration of these ethical questions by the Board of Councilors. We now believe that for the first time some really genuine progress has been made toward solution of what has been referred to as "the Trinidad problem." It is even possible, though we cannot predict it with any surety, that the Board may be able to report its decisions on these ethical questions before adjournment of this Annual Session. Even if not, we assure you the answers will be forthcoming within a very short time.

The Board of Councilors wishes to commend the new Advisory Committee to the UMWA Welfare Fund as well as the Board of Trustees and the Public Policy Committee for the excellent work previously done by them and their subcommittees. However, the Board of Councilors realizes and accepts its responsibility as the only body empowered under the Constitution of this Society to make final decisions on ethical questions. We assure the House of Delegates that whatever decisions are made by this Board will be made only with the best interests of physicians and their patients in mind.

In a number of matters that have been brought before the Board of Councilors within the last year, from one or another committee or official body within our Society, it has become increasingly evident that some of the agencies within our organization have made decisions involving legal questions without benefit of consultation with our retained attorney. Had some of these matters not reached the Board of Councilors for actual final decision, and had the Board of Councilors likewise failed to use legal counsel, this Society could have found itself in completely untenable positions several times within the last year. With the increasing complexity of actions our State Medical Society must undertake, the Board of Councilors therefore wishes to caution all boards, officers, and committees of the Society to make more and better use of our retained Legal Counsel now and in the years to come.

(b) We met this morning to consider a prob-

Significant advantages of

CARNATION INSTANT WHEAT

in the Basic Cereal Breakfast

Carnation Instant Wheat provides all the natural whole wheat values including B-vitamins, protein, phosphorus and iron—in natural, unharmed form. The low-heat processing in no way "denatures" the protein, sometimes adversely affected by the high-heat processing of most types of ready-to-eat cereals.

*The University of Iowa Breakfast Studies** clearly demonstrated the importance of a good breakfast in maintaining *mental acuity* as well as physical work output; and the equal efficiency for such maintenance of the basic cereal breakfast and the basic bacon and egg breakfast supplying the same amount of calories.

In encouraging better breakfasts, the physician may well include the basic cereal breakfast for variety and economy. In such breakfasts, Carnation Instant Wheat provides definite advantages compared to ready-to-eat cereals or a "toast and coffee" breakfast.

ALL THE WHOLE GRAIN VALUES

Per weight measure compared to enriched flour, Carnation Instant Wheat makes a significantly greater contribution in protein, phosphorus, iron, thiamin, nicotinic and pantothenic acid and pyroxidine. Therefore, additional enriched toast is not a nutritionally equal substitute for Carnation Instant Wheat in the basic cereal breakfast.

DELICIOUS, EASY TO PREPARE

Carnation Instant Wheat is rolled extra-thin and partially pre-cooked—cooks in "no time." It brings out the delicious nut-like flavor of natural whole wheat.

FOR LOW SODIUM DIETS

An average serving (1 oz. dry) contains not more than 1.4 mg. sodium. Thus Carnation Instant Wheat is suitable for low sodium diets and is frequently preferred over ready-to-eat cereals, which generally contain added salt.

IOWA BREAKFAST STUDY
BASIC CEREAL BREAKFAST

ITEM	WEIGHT OF SERVING gm.	PROTEIN gm.	ENERGY calories
Fruit	77	0.4	68
Cereal (dry wt.)	30	3.2	110
Enriched White Bread (toasted)	50	4.2	130
Sugar	10	0.7	40
Butter	10	0.1	73
Whole Milk	480	16.9	330

Calories	750	Fat (gm.).....	28
Protein (gm.).....	25	Carbohydrate	100

*Literature available upon request.
Address Nutritional Research Dept.,
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lem which has to do perhaps ultimately with a change in the By-Laws; it has been mentioned to members of the Board of Councilors on numerous occasions in the past year: that the membership at large is unable to find out what happens when cases are brought before the Board of Councilors. There is in Section 15, Chapter VII of the By-Laws this statement:

> "Names or other identifiable details relating to disciplinary matters shall in no case be included in reports of the Board of Councilors or the Board of Supervisors or in reports by individual members of those Boards."

It has been felt by many in the Society that when a final action is taken by the Board of Councilors it might be well to acquaint the House of Delegates with the action, with the members involved, and with whatever measures were taken of a punitive nature or to "leave the man off the hook." In about half the cases we hear penalties are not imposed on the men. Perhaps many of these men are found to be not guilty of anything when they are brought before the Board. It was the feeling at our meeting this morning that perhaps this should be changed.

Proposed Amendment

So I offer this as another supplemental report from the Board of Councilors, who suggest the amendment of Chapter VII, Section 15, by striking out the last sentence thereof and substituting therefor the following:

> "Names or other identifiable details relating to disciplinary matters shall in no case be included in reports of the Board of Supervisors or in reports by individual members of that Board. Published reports of the Board of Councilors or individual members thereof shall likewise omit such names or details; but the Board of Councilors shall, in a separate report submitted in Executive Session of the House of Delegates, report fully its findings and decisions, including the names of the principals, in all cases heard by the Board."

No further reports were offered by the Board of Supervisors, any individual officer of the Society, or any Committee except reference committees.

Chairman John L. McDonald stated one portion of the Report of the Reference Committee on Constitution and By-Laws and Credentials was supplemental, but suggested as it was incorporated with the entire report of the reference committee the supplement be deferred until consideration of the entire report. Speaker Weaver accepted this suggestion.

Reports of Reference Committees were then received.

Report of the Reference Committee on Public Health

Acting Chairman Robert B. Bradshaw presented the following report which was adopted section by section and as a whole:

(a) Your Reference Committee recommends the approval of the report of the Committee on Health Education, as carried on page 34 of the Handbook.

(b) Your Committee recommends approval of the report of the General Committee on Public Health, as carried on pages 49 and 50 of the Handbook.

(c) Your Committee recommends approval of the report of the Subcommittee on Cancer Control, as carried on pages 50 and 51 of the Handbook.

(d) Your Committee recommends approval of the report of the Subcommittee on Crippled Children, as carried on page 51 of the Handbook.

(e) Your Committee recommends approval of

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the report of the Subcommittee on Geriatrics, as carried on page 51 of the Handbook.

(f) Your Committee recommends approval of the report of the Subcommittee on Industrial Health, as carried on page 51 of the Handbook.

(g) Your Committee recommends approval of the report of the Subcommittee on Maternal and Child Health, as carried on page 52 of the Handbook.

(h) Your Committee recommends approval of the report of the Subcommittee on Rehabilitation, as carried on page 54 of the Handbook.

(i) Your Committee recommends the approval of the report of the Subcommittee on Rural Health, as carried on pages 54 and 55 and 56 of the Handbook.

The Reference Committee on Public Health wishes to commend this Committee on the excellent work done during the year.

(j) Your Committee recommends the approval of the report of the Subcommittee on Sanitation, as carried on page 56 of the Handbook.

(k) Your Committee recommends the approval of the report of the Subcommittee on Tuberculosis Control, as carried on pages 56 and 57 of the Handbook.

Report of the Reference Committee on Professional Relations

Chairman Donn J. Barber (Weld) presented the following report which was adopted section by section and as a whole: (With reference to subdivision (a) Dr. Barber stated: "This is what you have just talked about. You have heard the proposed amendment submitted by the Board of Councilors." With reference to subdivision (g): "Parenthetically I might add that there is a question involved in the Committee's report regarding out-of-state members, and we feel that this can best be handled on an administrative level.")

(The report is as follows:)

(a) Your Reference Committee recommends the adoption of the Report of the Board of Councilors appearing on page 16 of the Handbook. In this report the Board calls attention to Section 15, Chapter 7 of the By-Laws regarding anonymity of members relating to disciplinary matters. Your Committee suggests a review of this section of the By-Laws by the Committee on Constitution and By-Laws during the coming year, for the purpose of altering this section to permit revelation of names in executive sessions of the House of Delegates by properly constituted committees.

(b) Your Reference Committee recommends adoption of the Report of the Board of Supervisors appearing on page 16 of the Handbook. We wish to convey the sentiments of this Committee in terms of the highest praise for the members of this Board and for the informative report submitted. The members of the Society should be constantly cognizant of the many hours of arduous and sometimes unpleasant effort of the members of this Board and particularly of the Chairman and Secretary.

(c) Your Reference Committee recommends adoption of the Report of the Delegates to the American Medical Association appearing on page 19 of the Handbook, and suggests that delegates be placed on the Scientific Program of the Annual Meeting for a verbal report to the Society in addition to the written reports in the Journal and the Handbook.

(d) Your Reference Committee recommends adoption of the report of the Subcommittee on

Intraprofessional Insurance Problems as carried on page 44 of the Handbook, and of the Supplemental Report before the House of Delegates emphasizing the importance of Insurance Carriers being licensed by the State.

(e) Your Reference Committee recommends adoption of the Report of the Medicolegal Committee as appearing on page 45 of the Handbook, and wishes to compliment this Committee on its departure from the form of reports in previous years consisting of a few short uninformative sentences. The present report makes a successful effort to provide informative material of interest and concern to Society members. The Committee has shown commendable initiative in obtaining valuable statistical information on the subject of malpractice insurance.

(f) Your Reference Committee recommends adoption of the report of the Subcommittee on Blood Banks as carried on page 38 of the Handbook.

(g) Your Reference Committee recommends adoption of the Report of the Subcommittee on Distribution of Physicians, as carried on page 38 of the Handbook.

(h) Your Reference Committee recommends adoption of the Report of the Subcommittee on Hospital-Professional Relations as appearing on pages 41, 42, and 43 of the Handbook.

(i) Your Reference Committee recommends adoption of the Report of the Committee on Rocky Mountain Medical Conference, as carried on pages 61 and 62 of the Handbook.

(j) Your Reference Committee recommends adoption of the Report of the Committee on Physician-Nurse Relations, as appearing on pages 66 and 67 of the Handbook.

Report of the Committee on Constitution, By-Laws and Credentials

(As a Reference Committee)

Chairman John L. McDonald presented the report of the Committee on Constitution, By-Laws and Credentials (as a Reference Committee) which was adopted section by section and as a whole, as amended and handled as follows:

(a) In its capacity as a Reference Committee, the Committee on Constitution, By-Laws and Credentials has again considered the revision of Councilor Districts, as requested by the House yesterday.

A number of witnesses were heard, some of whom had questioned the wisdom of the revision when it was first proposed to the House. Their temporary objections actually had to do with another matter, which will be dealt with in a separate report by this Committee. All who have appeared before us now agree that the revision of the Councilor Districts is a wise one.

We therefore recommend that the revision, as published on pages 32-33 of the Handbook, be adopted, with this proviso:—That, should the physicians of Adams County organize a separate county medical society, the new society shall be automatically transferred to the newly-created Councilor District which will now represent the counties suburban to Denver.

(b) The House also referred to us, as a Reference Committee, President Newman's proposal to amend the By-Laws as to the time for presentation of the annual Presidential Address so that an incoming President's program could be laid before the House of Delegates in time for action at the same Annual Session.

We respectfully report that no amendment to the By-Laws is necessary to effect such a change.

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For one thing, the Program Committee already has authority to consult with the President-elect and arrange any desired time for this presentation. Further, the President-elect is already entitled under the By-Laws to propose any recommendations or make any report he so desires at the first meeting of the House of Delegates, even before the Scientific Session begins.

(c) The Committee on Constitution, By-Laws and Credentials has learned of considerable dissatisfaction with the new system of choosing a Nominating Committee and the new system of publishing nominations in advance of the Annual Session. This new system was adopted by an amendment of the By-Laws one year ago, but apparently the one-year experiment has not proved satisfactory to a great many delegates. The dissatisfactions that have been communicated to us likewise caused some temporary misunderstanding concerning the revision of Councilor Districts.

Many have felt that our present form of Nominating Committee, with nine members, is too large and cumbersome, and have suggested that we return to the old five-man committee of some years ago. Others feel that the plan of freezing the committee by Councilor Districts —one from each District—makes the committee too geographical and insufficiently representative of our major population centers.

Our Committee believes that a return to the number of seven on the Nominating Committee, which seemed to be satisfactory for several years until our experiment of just last year, that is the return to the number of seven on the Nominating Committee, is a sensible compromise. Our Committee believes that the exact size of the committee is not too important, however, so long as the gentlemanly agreement of many years' standing remains as such—whereby the major offices are alternated between Denver and the rest of the state and whereby Denver allows the rest of the state to choose its candidates and vice-versa.

However, our Committee has found an increasing resentment, especially among the younger members of the Society, against a policy which Nominating Committees have followed for a great many years, namely the policy of nominating only one candidate for each major office. We are therefore proposing an amendment which would largely return our procedure to the plan followed for at least some five or six years, until just this year, in regard to the selection of a Nominating Committee. We are also proposing that the Nominating Committee shall nominate a minimum of two qualified persons for each elective office.

We therefore present the following proposed amendment, which under the By-Laws must lie on the table for one day before final consideration.

Proposed Amendment

Amend Chapter VI, "Elections," by striking out the first section thereof and substituting the following:

"Section 1. Nominating Procedure. The House of Delegates shall, at its first meeting at each Annual Session, elect a Nominating Committee consisting of seven Delegates, no two of whom may be members of the same component society. This Committee shall be charged with the responsibility of nominating at least two* qualified persons for each Constitutional or other elective office to be filled at that Annual Session, and with nominating a place for the Annaul Session next ensuing any Annual Session the location of which has been selected by previous action of the House. The Committee shall report its nominations to the House of Delegates at least one day prior to the day when the election of officers is to be held. Additional nomina-

tions may be made from the floor of the House of Delegates at any time the House is in session subsequent to the report of said Committee and prior to the election."

This cannot be voted on because it must lie on the table for at least 24 hours; but we urge that Delegates discuss this proposed amendment **now**, so that if changes in it are desired by the House, they can be made now and the amendment in its final form can still be ready for final consideration at this Annual Session.

[There followed a brief discussion. The proposed amendment was amended by striking therefrom the word "two" in the phrase "two qualified persons" and then this section (c) of the Committee report was adopted without dissent, whereupon Speaker Weaver announced this amendment to the By-Laws would lie on the table until the next meeting of the House, which was later fixed as Friday, September 23, for the reason that the usual Third Meeting of the House was by vote cancelled.]

(d) This Committee has one more proposal to make which under our Constitution can only be presented, and must lie on the table for one year.

Most members of this House know, by now, that Colorado has two representatives in a nationwide study being conducted by the American Medical Association toward improvement in the self-discipline plans of our profession. Dr. George Unfug of Pueblo is a member of a special A.M.A. Committee to develop recommendations toward some uniform procedures of grievance, mediation, and other committees similar to our own Board of Supervisors, for the whole country. Our Society's Executive Secretary, Mr. Sethman, has been serving as one of three special consultants to that committee.

Your Committee on Constitution, By-Laws, and Credentials is aware that the recommendations of this national committee will include a standard, nation-wide nomenclature for such bodies. The recommendation will be made formal at the Clinical Session of the A.M.A. in Boston just two months from now, and it will recommend that every state medical society adopt the title "Grievance Committee" for the body serving such purposes. We ourselves as a committee prefer the title "Board of Supervisors" but we defer to the need for national standardization.

For this reason, and other reasons which will be made more clear when the A.M.A. Committee's report is published, your Committee recommends that this new name for our own Board of Supervisors be considered. This involves a Constitutional Amendment, and cannot be acted upon finally for a year.

Therefore, in order that we may be prepared to consider these recommendations when they become formalized without postponing final consideration for two years, your Committee proposes that the Constitution and the By-Laws of our Society be amended by substituting for the words "Board of Supervisors" the words "Grievance Committee" and for the word "Supervisors," where it appears alone, the words "Grievance Committeemen," wherever such words appear in our Constitution and By-Laws.

Your Committee on Constitution, By-Laws and Credentials introduces these amendments and asks that they lie upon the table for one year before final action is taken, as required by the Constitution of the Society.

Vice Chairman Matchett recited the published personnel of the Reference Committee on Miscellaneous Business and stated those in attendance at the two meetings held were Richard H. McIlroy, Pueblo, substituting for Chairman Eugene B. Ley, who could not be in attendance; Foster Matchett, Denver, Vice-Chairman acting as Chairman; Robert B. Patterson, Larimer; Warren W. Tucker, Denver; and Robert B. Waters, Boulder.

Vice Chairman Matchett submitted the following report, adopted section by section and as a whole, after discussion and amendment as indicated below:

Report of the Reference Committee on Miscellaneous Business

(a) Your Reference Committee recommends the approval of the report of the Subcommittee on Emergency Medical Services, as carried on page 40 of the Handbook whose Chairman is Roy L. Cleere. The Reference Committee, however, would like to re-emphasize the need for, and the value of, a detailed plan for Emergency Medical Services for disasters caused by wind, flood, fire, and possible wrecks, as well as planning to meet the disasters caused by atomic and hydrogen bombs. Also it is thought that massive stockpiling of medical supplies at locations where they can be quickly dispersed by air to the devastated areas, seems more plausible, and workable, than stockpiling on the periphery of the major cities.

(b) The Committee recommends the approval of the report of the Subcommittee on Entertainment, as printed on page 63 of the Handbook, and wishes to congratulate the members of the committee headed by William A. Hines for the efficiency of their work carried on this year.

(c) The Committee recommends the approval of the report of the Advisory Committee to the Auxiliary, as printed on page 53 of the Handbook, under the chairmanship of Karl Arndt.

(d) Your Reference Committee congratulates the Committee on American Medical Education Foundation and recommends the approval and acceptance of the report as carried on pages 65 and 66 of the 1955 House of Delegates Handbook, headed by Karl F. Sunderland, Chairman. Your Reference Committee requests the approval of the House of Delegates of the following: "Every effort should be extended to show how these funds are utilized, so that this vital activity can be presented to all practicing physicians for their continued annual support."

(e) The Committee recommends the approval of the report of the Committee on Military Affairs, found on page 66 of the Handbook, headed by Robert S. Liggett, Chairman, and wishes to submit a supplemental report, as follows:

In view of the fact that the Committee on Military Affairs has been inactive, the Reference Committee on Miscellaneous Business suggests that the membership of this Committee on Military Affairs be reduced to three members.

[This, subsection (e) was amended. See below.]

(f) The Reference Committee on Miscellaneous Business recommends the approval of the report of the Medical Student Loan Fund Committee, headed by J. Robert Spencer, as carried on page 67 of the Handbook, together with this supplement.

In view of the small number of Colorado physicians who have contributed to this Fund, it is the feeling of the Reference Committee that the Loan Fund should continue to be under the direction of a committee of the State Medical Society, but that there should be appointed in each component society, as an ex-officio member of this committee, one man, preferably a graduate of the University of Colorado Medical School, who would be responsible for distribut-

*Re-amended, see following paragraphs.

ing publicity and securing contributions from the members of his local society.

Following discussion of the status of the committee, Dr. Hendryson moved an amendment to the report, that the military affairs committee be considered as a standing committee of the House. The motion was seconded and carried without dissent; whereupon a motion to adopt the entire Reference Committee report as amended carried without dissent.

Chairman Clare C. Wiley submitted the following report which was adopted section by section and as a whole:

Report of the Reference Committee on Legislation and Public Relations

(a) Your Reference Committee recommends approval of the report of the Public Relations Steering Committee as carried on pages 13 and 14 of the Handbook. Your Committee feels that this report once again brings out the fact that the component Medical Societies are not as cognizant as they should be of Public Relations. It is felt that this Committee is most important and could do a tremendous job for the State Sociey as a whole and strongly recommends its continuance, with the Committee to follow the suggestions for the coming year as printed in the Handbook.

(b) Your Committee recommends approval of the report of the Subcommittee on Indigent Medical Services as carried on page 43 of the Handbook. However, it was brought to the attention of the Committee that there may well be problems arising in the component societies or with individual doctors, particularly concerning farm labor in the fruit growing sections of Colorado, which should be brought to the attention of the Committee. This Committee suggests that if this is a true problem in indigent medical care it should be brought to the attention of this Committee so that some action can be taken.

(c) Your Committee recommends approval of the report of the Subcommittee on Prepayment Services as carried on page 44 of the Handbook. We would like to strongly urge the use of the booklet entitled "A Good Health Plan Is Good Protection" by all physicians. It is each physician's job to see that this booklet is made available to his patients. Your Committee feels that this Subcommittee has done an excellent job in working out a new fee schedule with the Industrial Commission, and members of the Industrial Compensation fund, and should be commended for their work. However, as brought to the attention of this Committee, through a resolution presented to it, there is a definite and, we feel, unjustified discrimination in fees paid for Radiological work. It is strongly recommended by this Committee that an attempt be made by the Subcommittee on Prepayment Services, the Radiological Society and other interested persons to arrive at a fee schedule which will satisfy both the Radiologists and the General Practitioner by paying them the same fee for services performed.

(d) Your Committee recommends approval of the report of the Subcommittee on Veterans Medical Care as carried on page 45 of the Handbook. It is quite obvious that the practicing physician himself is many times to blame for sending a non-service connected disability to a Veterans Administration Hospital. Again we would like to strongly urge that the practicing physician should refer no case to a Veterans Administration Hospital except for definite and clear-cut service connected illness or disability.

(e) Your Committee recommends approval of the report of the Subcommittee on Mental Health as carried on pages 52 and 53 of the Handbook.

(f) Your Committee recommends approval of the report of the Subcommittee on Legislation as printed on page 58 of the Handbook. Your Committee feels that physicians individually and the State Medical Society as a whole are better known for work and efforts against certain legislation than they are for supporting legislation. We would suggest that the Public Policy Committee consider being more active in supporting or even sponsoring certain legislation which would benefit our patients and the public health.

(g) Your Committee recommends approval of the report of the Subcommittee on Publicity as printed in the Handbook on page 58 and would like to commend this committee on a difficult job well done.

(h) Your Committee recommends approval of the report of the Subcommittee on Weekly Health Column and Health Articles as carried on page 58 of the Handbook, and wishes to commend this committee for a most important public relations job very well done.

(i) Your Committee recommends approval of the report of the Public Policy Committee as a whole as carried on pages 59, 60, and 61 of the Handbook, and including the Supplemental Report as presented to the House of Delegates, with the following changes: That the first word of the fifth line in the ninth paragraph be changed from "and" to "but" so that the paragraph reads as follows: "it is the recommendation of the Committee to the House of Delegates that it rescind the action of the 1953 House of Delegates as carried on page 974, December, 1953, Medical Journal, but that the Society reaffirm its opposition to the principle of the general admission of patients to full tax-supported institutions on a full participating Blue Cross basis." The Committee also requests that the next to the last paragraph on the committee's report, as carried on page 61, be stricken from the report. This Committee, as well as other physicians appearing before it, feels that the special committee appointed to study the problems between physicians and the UMW in the Trinidad area should be commended for the tremendous effort they put forth in attempting to resolve this problem.

(j) This Committee recommends the approval of a report of the Advisory Committee to United Mine Workers Welfare and Retirement Fund as presented before the House of Delegates at its first meeting. We suggest that the House of Delegates again go on record as approving the policy of genuine free choice of physician in guiding the deliberation of the committees having to deal with the problem, and that the House further instruct the Delegates to the A.M.A. to request that appropriate committees of that body also study the problem as relates to the UMW Fund and other similar funds which in the future might affect this principle of free choice of physician, as well defined in the Principles of Ethics of the AMA, with the view of condemning any policy which is contrary to these principles. Although this committee has been only recently reactivated, they have been working very diligently and should be commended heartily for a difficult job well done.

(k) Your Committee recommends approval of the report of the Automotive Safety Committee as carried on page 64 of the Handbook, with the following correction: In paragraph 4, line 7, the word "the" should be deleted. In paragraph 4, line 15, the word "that" should be deleted, and the words "Canadian Medical" be inserted.

(l) Your Committee recommends approval of

the report of the Blue Shield Fee Schedule Advisory Committee as presented to the House of Delegates at its first meeting. It has been brought to the attention of the committee that the problem related to Blue Shield benefits for old age pensioners at a reduced rate, and that the Blue Shield Fee Schedule Advisory Committee should be a rotating committee, were both acted upon favorably by the House of Delegates last year. To date no action apparently has been taken on either of these. Since definite action has been taken by the House of Delegates on these matters, it is important that the Board of Trustees see that they are carried out in the near future. It is hoped that all physicians involved are cognizant of the problem Blue Shield is facing concerning assistant surgeon's fees, and will cooperate fully with Blue Shield in correcting this situation.

(m) Your Committee recommends approval of the report of the Representatives to the Adult Education Council as carried on page 68 of the Handbook.

(n) Your Committee recommends approval of the Report of the Representative to the Rocky Mountain Radio Council, as carried on pages 68 and 69 of the Handbook. This Committee would like to bring to the attention of the House of Delegates that Station KLZ-TV has been most cooperative in every way with our Representative to the Rocky Mountain Radio Council, and has made possible our Society's successful public TV program at a most minimal cost to the State Society. It is suggested by this Committee that the President of the State Society be requested to thank KLZ-TV by letter for these courtesies.

Chairman Gatewood C. Milligan, Arapahoe, submitted the following report which was adopted section by section and as a whole as amended with respect to subsection (b):

Report of Reference Committee on Board of Trustees and Executive Office

(a) Your Reference Committee on Board of Trustees and Executive Office has met and considered in detail the matters referred to it, listened to testimony, and questioned witnesses in arriving at its recommendations. We wish to point out that time limitations preclude exhaustive study of some of the problems involved, and represent only a critical review, designed to stimulate considered action by the House.

Your Reference Committee approves the report of the Board of Trustees as printed on pages 8, 9 and 10 of the Handbook, and that portion of page 11, down to the line 9, which begins, "summary." We wish to commend the Board on appointing and authorizing special representatives to the several important national bodies, last paragraph, page 9.

(b) Your Committee disapproves, paragraph 2, page 11: "Summary," down to "Medical School," but does approve the principle of private practice by full-time faculty outside the confines of a tax-supported institution. [Not adopted, see immediately below.]

Dr. Milligan moved adoption of Section (b) (above) of the Reference Committee report, and his motion was seconded. It was then discussed by several Delegates and ex-officio members of the House. Dr. E. Stewart Taylor moved to amend this section of the Reference Committee's report by adopting, instead, that section of the Board of Trustees' published report in the Handbook which the Reference Committee had just disapproved. This motion, duly seconded, was in turn discussed at length.

At the conclusion of the discussion, upon request duly supported, Speaker Weaver ordered a secret ballot upon Dr. Taylor's motion. The roll call was verified, ballots were spread by appointed tellers, and upon completion of the count the tellers reported to the Speaker that Dr. Taylor's motion to amend had been adopted by a vote of 33 to 28.

Dr. Milligan then moved adoption of Section (b) of the Reference Committee report as amended. The motion was seconded, and further discussion followed to clarify the meaning of the actions being taken. It was agreed that by adopting the now current motion of Dr. Milligan the House would be adopting the section of the Board of Trustees report as published in the Handbook, would be rejecting the first clause of Section (b) of the Reference Committee (above), and would be finding the remaining clause of that sentence of the Reference Committee report to be redundant. Dr. Milligan's motion to adopt the Section as amended was then carried by viva voce vote.

(c) Your Committee approves the remainder of the report of the Board of Trustees with the proviso that the Summary of Relations of the Colorado State Medical Society, Board of Regents, and the University of Colorado, State Medical Society be named "President Samuel P. Newman's Summary of the Relations of the Colorado State Medical Society—Board of Regents—University of Colorado School of Medicine."

(d) Your Committee approves the budget report as amended, with the amended figure of adding $1,000 in receipts which comes from the balance of 1954-1955 funds by transfer, and changing the figure "Annual Session," by adding $1,000 for purposes of honoring the fifty-year men and making the appropriate changes in the total. Your Committee also approved the Auditor's report and found it to fulfill the requirements of procedure. The audit was distributed to you yesterday, in the Supplemental Report. We wish to commend the Board for its good husbandry at a time when good husbandry seems to be an exceptional virtue.

(e) The Committee has considered the supplemental report of the Board of Trustees' subcommittee, "Building Committee," page 14, and the report of the President-elect together with it. We recommend that the House of Delegates renew its grant of authority to the Board of Trustees to proceed with construction of a suitable office building in whatever amount it shall deem necessary, so long as it does not necessitate a special assessment on the membership, an increase of dues for that purpose, or deplete the surplus funds below $25,000, the minimum safe reserve according to our auditors.

(f) The Committee approves the report of the Subcommittee on Indoctrination as printed on page 15.

(g) The Committee approves the report of the Foundation Advocate, pages 19 and 20.

(h) The Committee has considered the report of the Executive Secretary, pages 20, 21, 22, 23, 24 and 25, and the supplement "Status of Membership," page 25.

(i) Page 69, Middle of the page, Recommendations. Again this involves an expenditure of funds, and we are informed that this item has been taken care of by item 18-c of the 1955-56 budget, page 13.

(j) Your Committee has considered the supplemental report of the Board of Trustees dated September 15, 1955, as distributed yesterday. We have in previous action approved the audit, and

now wish to approve the remainder of this supplement.

(k) Your Committee has considered the Supplemental report of the Board of Trustees, Report of the Code of Cooperation Committee distributed yesterday. We wish to approve this report, and to commend the committee for its actions, which we feel are a definite step further in promoting the workability of the Code. We want to commend particularly the action creating an executive committee which can meet on call whenever a problem occurs or is foreseen, with the hope of resolving difficult situations before they snowball into major misunderstandings. The changes in the Code are not of profound significance in the opinion of your Committee, since the working of the Code is dependent upon understanding and a spirit of cooperation on the part of the full membership of the several bodies party to the Code. We do feel that these intangibles are promoted by the discussions which produced such changes. We cannot commend these actions without recognizing the tremendous contributions made by Dr. John Bouslog in pioneering and nurturing this project.

[It was noted that the personnel of the Reference Committee on Board of Trustees and Executive Office was altered from that published in the Handbook by substituting T. W. Miller for Roscoe H. Ackerly and S. B. Childs for Rex L. Murphy.]

Chairman Milligan: I do wish to thank the Committee for its perserverance. I have one other suggestion but this is not a matter for action; and that is, that in the future I would suggest that the Speaker does not appoint the chairmen of major committees to reference committees, but rather that they be held available to any reference committee which might want to confer with them.

There was no Unfinished Business.

New Business

Delegate Gordon H. Vandiver presented the following resolution from the Otero County Medical Society which was referred without discussion to the Reference Committee on Professional Relations, by Vice Speaker Condon:

Resolution

WHEREAS, There is an undisputed shortage of nurses in all fields; and

WHEREAS, The La Junta Mennonite School of Nursing, a 41-year-old institution operating in conjunction with the Mennonite Hospital and Sanatorium at La Junta, Colorado, is faced with numerous difficult problems at this time in an attempt to remain an accredited school of nursing and keep it doors open; and

WHEREAS, The Board of Education of the Mennonite Church which operates the school has indicated that they are anxious to keep this school open, providing the Colorado State Board of Nursing Examiners will offer much needed assistance, cooperation and encouragement in working out their problems;

THEREFORE, BE IT RESOLVED, That the Colorado State Medical Society, through its officers, nurse relations committee and members, communicate with the members of the Colorado State Board of Nursing Examiners requesting that they offer to the La Junta Mennonite School of Nursing the needed assistance, cooperation and encouragement in keeping their school of nursing open and accredited.

Vice Speaker Condon announced it appeared the House had so expedited their business it might not be necessary to have the Third Meeting. Chairman John L. McDonald, of the Reference Committee on Constitution, By-Laws and Credentials, asked for a brief recess for a brief meeting of his committee. Vice Speaker Condon ordered a brief recess, by unanimous consent.

Chairman John L. McDonald submitted the following report, upon which no action was necessary, and the proposed amendment was laid on the table for consideration at the final meeting of the House:

Supplemental Report of Committee on Constitution, By-Laws and Credentials (as a Reference Committee).

The Committee has considered the suggestion made by the Board of Councilors to amend Chapter VII, Section 15, by striking out the last sentence thereof and substituting therefor the following: "Names or other identifiable details relating to disciplinary matters shall in no case be included in reports of the Board of Supervisors or in reports by individual members of that Board. Published reports of the Board of Councilors or individual members thereof shall likewise omit such names or details; but the Board of Councilors shall, in a separate report, submitted in Executive Session of the House of Delegates, report fully its finding and decision, including the names of the principals in all cases heard by the Board." We favor this report and recommend that it lay on the table for consideration at the next meeting.

There was no further New Business.

The House then voted without dissent to cancel the usual Third Meeting of the House of Delegates scheduled for two p.m. September 22. Routine announcements were made, and Vice Speaker Condon declared the House adjourned until eight o'clock Friday, September 23, 1955.

THIRD MEETING
Friday, September 23, 1955

Vice Speaker Condon called the House to order at eight o'clock a.m. There was no additional report by the Credentials Committee. Roll Call disclosed sixty-two accredited delegates present, more than a quorum. By proper procedure Alternate Elson F. Pierce was seated in the absence of Delegate John W. Bradley of El Paso County Medical Society.

The House voted without dissent to dispense with the reading of the Minutes of the Second Session. At the request of Vice Speaker Condon Executive Secretary Sethman re-read the complete Report of the Nominating Committee as printed on pages 48 and 49 of the Handbook.

Chairman Edgar A. Elliff submitted the following report which was filed:

Supplemental Report of Nominating Committee

Due to the changes which the House of Delegates has now made in the boundaries of certain Councilor Districts (pages 32 and 33 of the Handbook) it becomes necessary to submit a supplemental report for the Nominating Committee with regard to nominations of Councilors.

The re-districting of Eastern and Southeastern Colorado has combined parts of old Districts No. 4 and 5, leaving two Councilors in a new District, called District No. 9. Your Committee reports that Dr. Ward C. Fenton, of Rocky Ford, has withdrawn from the Board of Councilors leaving Dr. Scott A. Gale of Pueblo as the Councilor for the remaining year of a three-year term serving the new District.. This part of our report is for your information and will not require any election by the House of Delegates.

Due to the changes whereby **old** District No. 9 was combined with part of **old** District No. 8 to become a **new** District now numbered District No. 6, the Nominating Committee finds it necessary to withdraw the name of Dr. Ray T. Witham from its report as published in the Handbook.

for equanimity[1,2]

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Meprobamate

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Wyeth®
Philadelphia, Pa.

new anti-anxiety factor with muscle-relaxing properties

relieves tension

*Trademark

Your Committee nominates as Councilor for three years representing this new District No. 6 the name of Dr. Harvey Tupper of Grand Junction.

The changes you have brought about have created two new Districts. To abide by the Constitution providing for overlapping terms of all of the nine Councilors, one of these Districts must be filled this year for a one-year term; the other for a three-year term.

Your Nominating Committee presents the name of Dr. Roger G. Howlett, Sr., of Golden, as nominee for Councilor of the **new** District No. 2 which serves the suburban areas of Denver. This nomination is for a one-year term.

Your Committee presents the name of Dr. Harry C. Bryan, of Colorado Springs, as Councilor of the **new** District No. 4, which consists of El Paso County Medical Society. This nomination is for a three-year term.

Election of Officers

Vice Speaker Condon called for further nominations for the office of **President-elect** of the Society from the floor of the House. There being no further nominations for that office, the Vice Speaker declared nominations closed and **Dr. George R. Buck,** of Denver, was elected by acclamation to succeed Dr. Robert T. Porter, of Greeley, for a one-year term.

Vice Speaker Condon declared Dr. Buck elected and appointed Past Presidents Ervin A. Hinds and William A. Liggett to escort Dr. Buck to the stand. Dr. Buck acknowledged the applause of the House and spoke as follows:

Dr. Buck: "I am most sensitive to and appreciative of the honor you have seen fit to bestow on me this morning. I wish I could look forward with all the enthusiasm I might have had a few years ago to fill this position. I am too sensitive to the awesome responsibilities the titular leader of this organization bears to be naive about the position. I only pray that you can be patient and forbearing with me; and on my part I will try to make you a good officer." (Applause.)

There were no further nominations for the office of **Vice President,** the Vice Speaker closed the nominations, and **Dr. Leo W. Lloyd,** of Durango, was elected by acclamation.

There were no further nominations for the office of a **Trustee** for a three-year term to succeed Dr. William R. Lipscomb, of Denver, the Vice Speaker closed the nominations, and **Dr. Terry J. Gromer** was elected by acclamation.

There were no further nominations for a **Trustee** for a three-year term to succeed **Dr. Thomas K. Mahan,** of Grand Junction, the Vice Speaker closed the nominations, and Dr. Mahan was elected by acclamation to succeed himself.

Vice Speaker Condon then proceeded by independent actions in each instance to conduct the election of all other nominees submitted to the House by the Nominating Committee, as well as those nominated from the floor, and the House elected those nominees in each instance by acclamation, with the exception of a vote by ballot to elect members of the Board of Supervisors. Officers so elected are as follows:

A **Councilor** for District No. 7, for a three-year term to succeed Dr. Leo W. Lloyd, of Durango: **Dr. Charles L. Mason,** of Durango.

A **Councilor** for District No. 8, for a three-year term to succeed **Dr. Harvey M. Tupper,** of Grand Junction: Dr. Tupper to succeed himself.

[Executive Secretary Sethman received permission of the House without dissent to correct the District numbers in the Minutes because by action at the second meeting the House actually changed the number of District No. 7 and 8 as printed in the Handbook.]

A **Councilor** for new District No. 6, for a three-year term, to succeed **Dr. Harvey M. Tupper,** of Grand Junction (old District No. 8); Dr. Tupper to succeed himself.

A **Councilor** for new District No. 2, for a one-year term: **Dr. Roger G. Howlett, Sr.,** of Golden.

A **Councilor** for new District No. 4, for a three-year term: **Dr. Harry C. Bryan,** of Colorado Springs. (Old District No. 5.)

Vice Speaker Condon re-read the Report of the Nominating Committee with reference to its nominees for six members of the Board of Supervisors, as printed at page 49 of the Handbook, and called for any further nominations.

Dr. Carl W. Swartz (Pueblo) nominated Dr. William N. Baker of Pueblo for the Board of Supervisors. Vice Speaker Condon pointed out that with seven names and only six to be elected, it was necessary to ballot. As the ballots were being passed out the following were properly and regularly seated without dissent:

Alternate Walter Boyd, in the absence of Delegate Eugene Wiege, of Weld County.

Alternate Freeman H. Longwell, in the absence of Delegate Ralph H. Verploeg, of Denver.

Alternate Woodrow S. Hazel, in the absence of Delegate Howard F. Bramley, of Denver.

Six Members of the Board of **Supervisors,** each for a two-year term and no two from the same component society, were declared elected following the ballot as follows:

Lawrence W. Holden, Boulder County Medical Society.

Robert C. Lewis, Jr., Garfield County Medical Society.

William N. Baker, Pueblo County Medical Society.

Kenneth H. Beebe, Northeast Colorado Medical Society.

James S. Orr, Mesa County Medical Society.

Duane F. Hartshorn, Larimer County Medical Society.

Further individual officers elected, by acclamation, were:

A **Delegate to the American Medical Association** for a two-year term beginning January 1, 1956, to succeed Dr. George A. Unfug, of Pueblo: **E. H. Munro,** Grand Junction.

An **Alternate Delegate** to the American Medical Association for a two-year term beginning January 1, 1956, to succeed Dr. E. H. Munro, of Grand Junction: **Dr. Harlan E. McClure,** Lamar.

A **Speaker** of the House of Delegates for a one-year term to succeed Dr. John A. Weaver, of Greeley, **Dr. William B. Condon,** of Denver.

A **Vice Speaker** of the House of Delegates for a one-year term to succeed Dr. William B. Condon, of Denver: **Dr. Carl W. Swartz,** of Pueblo.

A **Foundation Advocate** for a one-year term to succeed **Dr. Walter W. King,** of Denver: Dr. King to succeed himself.

Denver, Colorado, was selected as the place for holding the 89th Annual Session of the Society in 1959.

Past President William H. Halley addressed the House briefly, humorously welcoming retiring-President Samuel P. Newman into the company of Past Presidents.

No Board or Officer of the Society had any further report to offer to this Annual Session except Executive Secretary Sethman, who asked and received unanimous consent to address the House in Executive Session at the end of the Order of Business.

No standing committee, special committee, or

any special representative had any further report to offer.

Additional Reports of Reference Committees

In the temporary absence of Chairman William A. Ligget, acting Chairman Edward C. Budd submitted the following report which was adopted section by section and as a whole without dissent:

Report of the Reference Committee On Scientific Work

(a) Your Reference Committee recommends approval of the Report of the Committee on Library and Medical Literature as carried on page 35 of the Handbook, and further recommends that this House of Delegates direct the Board of Trustees to implement the Committee's recommendations.

(b) Your Reference Committee received an amendment to the Report of the Committee on Medical Education and Hospitals, which reads as follows:

> This committee requests that an amendment be made to its report as published in the House of Delegates Handbook. On page 37 in paragraph numbered 6 following the word "selected" insert the words "by the medical school." The complete sentence would then read "Suitable members of both the full-time and the volunteer faculty of the medical school will be carefully selected by the medical school and asked to volunteer to serve as visiting teachers in one hospital per year."

Your Reference Committee accepted this amendment and recommends that the report as printed in the Handbook be so changed.

(c) Your Reference Committee recommends the approval of the Report of the Committee on Medical Education and Hospitals as printed on pages 36, 37, and 38 of the Handbook, as amended, and recommends that the House revise its action of September 23, 1954, as suggested in paragraph A of the report with the elimination of the last part of the last sentence which now reads as follows: ". . . and that the speakers who are members of this Society should receive no honorarium," and that the sentence be changed to read "and that acceptance of honoraria by members of this Society be optional."

(d) Your Reference Committee recommends the approval of the Report of the Subcommittee on Rocky Mountain Cancer Conference as printed on page 54 of the Handbook, and commends the Committee for an excellent job well done.

(e) Your Reference Committee recommends approval of the Report of the Committee on Scientific Program, as printed on pages 62 and 63 of the Handbook. Your Reference Committee solicits the commendation of the House for the members of this Committee whose capable planning has made this scientific session a success.

Speaker Weaver: The next report should be from the Reference Committee on Professional Relations. (No response.) There are two portions of Unfinished Business that were referred to that committee. We will have to relieve the Reference Committee on Professional Relations of its duty and have the House of Delegates as a whole finish it at this time. I will ask Mr. Sethman to read that portion of the Unfinished Business.

Secretary Sethman read from the Minutes of yesterday's meeting:

> Dr. Lloyd presented a Supplemental Report on behalf of the Board of Councilors, reporting conclusion of a case involving a component society's rejection of an application for membership and direction to the component society to elect the applicant to membership as the Board found no grounds for rejection of his application; also, concerning the recently reconstituted Advisory Committee to the United Mine Workers Welfare and Retirement Fund, stating that the Board could not predict with any certainty it would be able to report its decisions on certain ethical questions before the adjournment of this Annual Session, but that the answers would be forthcoming within a short time; commending the new Advisory Committee to the UMWA Welfare Fund as well as the Board of Trustees and Public Policy Committee for excellent work previously done by them and their subcommittees; and cautioning all boards, officers and committees of the Society to make more and better use of the Society's legal counsel in the future.
>
> This portion of the Supplemental Report was referred to the Reference Committee on Professional Relations.

Speaker Weaver called for discussion. There was none and a motion for approval of the Supplemental Report of the Board of Councilors regularly seconded, with discussion, was carried without dissent.

Secretary Sethman re-read the resolution* introduced by Delegate Gordon H. Vandiver of Otero County and referred to the Reference Committee on Professional Relations at yesterday's meeting.

Speaker Weaver called for discussion from the floor. The resolution was discussed by several. On motion properly made and seconded, the resolution was adopted without dissent.

Further Unfinished Business

At the request of Speaker Weaver, Secretary Sethman presented amendments to the By-Laws which had lain on the table for the required day. Following discussion, the House adopted the following amendment to Chapter VII, Section 15 of the By-Laws on motion of Dr. J. L. McDonald, with one Delegate voting "No."

> Names or other identifiable details relating to disciplinary matters shall in no case be included in reports of the Board of Supervisors or in reports by individual members of that Board. Published reports of the Board of Councilors or individual members thereof shall likewise omit such names or details; but the Board of Councilors shall, in a separate report submitted in Executive Session of the House of Delegates, report fully its findings and decisions, including the names of the principals, in all cases heard by the Board.

The House then adopted the following amendment to Chapter VI of the By-Laws unanimously, on motion of Dr. McDonald:

> Section 1. Nominating Procedure. The House of Delegates shall, at its first meeting at each annual session, elect a Nominating Committee consisting of seven delegates, no two of whom may be members of the same component society. This Committee shall be charged with the responsibility of nominating at least one qualified person for each Constitutional or other elective office to be filled at that annual session and with nominating a place for the annual session next ensuing any Annual Session the location of which has been selected by previous action of the House. The Committee shall report its nominations to the House of Delegates at least one day prior to the day when the election of officers is to be held. Additional nominations may be made from the floor of the House of Delegates at any time the House is in session subsequent to the report of said Committee and prior to the election.

The Speaker declared the By-Laws so amended. There was no further unfinished business on the desk.

Speaker Weaver called on President Newman, who addressed the House briefly, thanking all for the cooperation he had received during his term of office, expressing the opinion it had been an excellent year, and asking that the same cooperation be accorded the incoming officers.

The next order of business was New Business, but no member offered any new business.

*See page 1017.

Speaker Weaver then declared the House in Executive Session and asked anyone who was not either a member of the House of Delegates or a member of the Society to leave the room. At the close of the Executive Session, no portion of which was recorded in any manner, the Speaker declared the House in open session and at his request the Secretary certified that his official desk was clear except for announcements.

Speaker Weaver thanked the members of the House of Delegates and the chairmen and members of the reference committees for the expediency with which the transactions of the House of Delegates had been accomplished and, there being no further business to come before the House, Speaker Weaver declared the House of Delegates adjourned sine die.

The foregoing condensation of the Minutes of the Eighty-fifth Annual Session is respectfully submitted to the Society.

HARVEY T. SETHMAN.
Secretary, House of Delegates.

COLORADO HOUSE OF DELEGATES, 1955*

Speaker: John A. Weaver, Jr.

Vice Speaker: William B. Condon

SOCIETY	Active Members 12/31/54	Apportionment	Delegates	Alternates	Term Expires Jan. 31 of
Arapahoe	43	2	**G. C. Milligan**	John A. Davis	1956
			John Simon, Jr.	S. C. Percefull	1957
Boulder	71	3	**O. W. Allison**	M. G. Ringer	1956
			R. M. Waters	L. E. Maurer	1957
			C. C. Wiley	Harry Wherry	1957
Chaffee	13	1	**E. C. Budd**	Mason Light	1956
Clear Creek	48	2	**H. M. Van der Schouw**	Thomas R. Thorn	1956
			Michael Ryan	Donald Plumb	1957
Delta	12	1	**Lawrence L. Hick**	Charles Frey	1957
Denver	938	38	**John H. Amesse**	Donald E. Newland	1956
			Ervin A. Hinds	George R. Buck	1956
			McKinnie L. Phelps	Robert C. Shattuck	1956
			Wm. M. Covode	**John S. Bousleg**	1956
			J. A. Philpott, Jr.	Monroe R. Tyler	1956
			W. A. H. Rettberg	David R. Akers	1956
			Mariana Gardner	**Samuel B. Childs**	1956
			Terry J. Gromer	Wm. R. Coppinger	1956
			Frank B. McGlone	Robert M. Maul	1956
			Isadore Gersh	Robert F. Bell	1956
			Cyrus W. Anderson	Felice A. Garcia	1956
			Howard F. Bramley	**Woodrow S. Hazel**	1956
			Robert K. Brown	Robert Woodruff	1956
			Foster Matchett	Edmond F. Cohen	1956
			N. Paul Isbell	William A. Hines	1956
			Rex Murphy	**A. J. Kaiver**	1956
			Ralph H. Verploeg	**Freeman H. Longwell**	1956
			Richard C. Cullen	**Herman I. Laff**	1956
			Walter E. Vest, Jr.	Melvin A. Johnson	1956
			Harry C. Hughes	Mordant E. Peck	1956
			John B. Grow	**Howard T. Robertson**	1957
			Bernard T. Daniels	Joseph H. Patterson	1957
			Charles G. Freed	Marshall G. Nims	1957
			William A. Liggett	S. E. Blandford, Jr.	1957
			Carl H. McLaughlin	Rudolf E. Giehm	1957
			J. Robert Spencer	Thos. H. Mahony, Jr.	1957
			Alexis E. Lubchenco	Karl F. Sunderland	1957
			H. Calvin Fisher	Edward J. Meister	1957
			E. Paul Sheridan	Homer G. McClintock	1957
			Michael A. Lubchenco	Bradford Murphey	1957
			Gordon Meiklejohn	Lloyd V. Shields	1957
			Irvin E. Hendryson	John C. Long	1957
			Ralph M. Stuck	**Lawrence T. Brown**	1957
			Byron I. Dumm	**Joseph B. McCloskey**	1957
			John C. McAfee	V. G. Cedarblade	1957
			E. Stewart Taylor	**Franklin G. Ebaugh**	1957
			C. A. McLaughlin, Sr.	Chauncey A. Hager	1957
			Warren W. Tucker	**Marvin E. Johnson**	1957
Eastern	13	1	W. L. McBride	J. O. Clanin	1956
El Paso	155	7	**John L. McDonald**	Maurice E. Snyder	1956
			Walter C. Herold	Sam H. Brown	1956
			J. W. McMullen	Robert H. Smith	1956
			Roland Anderson	Vernon L. Bolton	1957
			Kenneth Gloss	Kenneth Dumars	1957
			William Campbell	Gerald Smith	1957
			John W. Bradley	**Elson F. Pierce**	1957
Fremont	14	1	**H. C. Grabow**	Geo. C. Christie	1957
Garfield	12	1	**Robert C. Lewis, Jr.**	Alan A. Basinger	1957
Huerfano	5	1	James M. Lamme, Sr.	N. S. Saliba	1957
Lake	8	1	Franklin McDonald	George Stanley	1956
Larimer	52	3	**Sion W. Holley**	Blair Adams	1956
			Robert Patterson	A. S. Rumley	1957
			Donald Arndt	N. Paul Anderson	1957
Las Animas	8	1	**Lee J. Bouchat**	David Barglow	1956
Mesa	46	2	**Ernest A. Jaros**	J. E. Hyland	1956
			H. R. Bull	Paul Stidham	1957
Montrose	13	1	Thomas O. Plummer	Roy F. Carpenter	1957
Morgan	14	1	**Clemens F. Eakins**	R. B. Richards	1956
Northeast	31	2	**Edgar Elliff**	Lloyd W. Anderson	1956
			John Lundgren	Robert Ludwick	1957
Northwestern	12	1	**Ligon Price**	W. F. Deal	1957
Otero	20	1	**Gordon H. Vandiver**	Wm. R. Sisson	1957
Prowers	13	1	**H. E. McClure**	Edwin C. Likes	1957
Pueblo	109	5	**Carl W. Swartz**	F. G. Tice	1956
			Roscoe Ackerly	**T. W. Miller**	1956
			E. B. Ley	**Richard McIlroy**	1957
			J. B. Farley	**R. A. Nethery**	1957
			George M. Myers	Frank Stander	1957
San Juan	28	2	**Charles Mason**	Edward G. Merritt	1956
			Erwin P. Wenz	Tullius Halley	1957
San Luis	29	2	**A. B. Gjellum**	Howard M. Rupp	1956
			Robert B. Bradshaw	Chas. A. Cassidy	1957
Washington-Yuma	11	1	A. T. Waski	**C. J. Bennett**	1957
Weld	68	3	**Donn J. Barber**	S. E. Widney	1956
			Eugene Wiese	**Walter Boyd**	1956
			Fred Houkema	William Conte	1957
Total voting membership of house		85			

*Names in **bold type** were officially seated in one or more meetings of the House at the Annual Session.

Component Societies

BOULDER COUNTY

The Boulder County Medical Society heard Dr. Lynwood M. Hopple, Colorado Springs, discuss child guidance problems at its regular monthly meeting October 13. Elected to membership was Dr. Hubert K. Knudson, who transferred from Clinton County Medical Society, Iowa.

WELD COUNTY

The Weld County Medical Society held its regular meeting at the Weld County General Hospital in Greeley October 3. A paper on Civil Defense was delivered by Dr. Lindquist, District 6 Director of Civil Defense. This was followed by a report on the Annual Session held in Denver September 20 to 23.

J. J. ZUIDEMA, Secretary.

OXYGEN ADMINISTRATION AND RETROLENTAL FIBROPLASIA RECOMMENDATIONS

From the Colorado State Department of Public Health and the Premature Infant Center, Colorado General Hospital, September, 1955.

The findings in studies at this premature infant center are in agreement with the conclusions of other investigators* regarding a close association between administration of high concentrations of oxygen and blindness due to retrolental fibroplasia. Since reducing the amount **and duration** of oxygen therapy has not increased the premature infant mortality rate, state health departments are urging immediate application of this information by physicians and hospital personnel.

The following precautions are recommended:

1. That oxygen be administered to premature infants only on the specific order of a physician.

2. That oxygen concentrations greater than 40 per cent not be given except as an emergency procedure and then only for the duration of the emergency.

3. That oxygen concentrations be measured at least every twelve hours with an oxygen

*Bibliography supplied on request.

(Continued on Page 1024)

Colorado Annual Session Banquet Sets New Attendance Record

In part because of the special ceremony pictured on the next page, but even more because of careful advance planning and hard work on the part of the Woman's Auxiliary, the annual banquet at the Colorado State Medical Society's session last month broke all records for attendance. All decorations, a special menu, a floor show, after-dinner dancing and, in fact all arrangements except the Fifty-Year Club speechmaking, was in the hands of the Auxiliary. At this dinner, there was also presented to the Society for its historical archives a photograph made of the St. Anthony Hospital Staff in 1900. The top picture shows about half of the banquet group in the Shirley-Savoy Hotel's Lincoln room. Below, in pictures taken just before the doors were opened, members of Auxiliary committees are arranging some of the decorations in circus motif. Included are Mesdames Howard F. Bramley, William R. Coppinger, J. Robert Spencer.

A total of 385 members and wives enjoyed the dinner, ceremonies and entertainment.

COLORADO HONORS ITS SENIOR MEMBERS

The Gold Pin
(enlarged)

Featured at the Colorado State Medical Society's 83th Annual Session Banquet September 22 was the ceremony of awarding gold pins to all living members who had graduated fifty or more years before. Top row, left to right: Dr. Samuel P. Newman, Denver, retiring President of the Society, awards a pin to Dr. Walter W. King, Denver, one of the Society's Past Presidents; Dr. William C. Service, Colorado Springs, Treasurer, gives one to Dr. Ella A. Mead, Greeley, formerly for twenty-six years a member of the Society's Board of Councilors, and Dr. James M. Perkins, Denver, Constitutional Secretary, similarly congratulates Dr. George P. Lingenfelter, Denver, another Past President. Center: Dr. Nicholas A. Madlar, Greeley, Past President, accepts the pins on behalf of all the 50-year-club members (his talk was reproduced on page 902 of the October Journal). Bottom, left to right: Dr. C. Walter Metz, Denver, Trustee, hands one of the pins to Dr. T. Leon Howard, Denver; Dr. Thomas K. Mahan, Grand Junction, Trustee, gives one to Dr. Walter S. Chapman, Walsenburg, and again to Dr. Grant H. John, Englewood.

OXYGEN ADMINISTRATION—

(Continued From Page 1021)

analyzer†. (Regulation of concentration by liter flow is only approximate, but it is suggested that until an oxygen analyzer can be obtained that not more than two liters per minute be used.)

4. That oxygen be discontinued after twenty-four hours and re-started only for specific symptoms. When oxygen must be used for longer than two to three days, it is especially important to keep the concentration below 40 per cent.

The use of low oxygen concentrations for short periods of times as outlined above has led to a marked drop in both severity and number of cases of residual retrolental fibroplasia in premature infants at Colorado General Hospital. However, the incidence of premanent eye damage has not been completely eliminated, particularly in very small infants, and other possible etiological factors are currently under investigation.

†A Beckman oxygen analyzer can be obtained from Arnold O. Beckman, Incorporated, 1020 Mission, South Pasadena, California, for approximately $225.00.

Obituaries

THOMAS G. CORLETT

With the death on August 12 of Dr. Thomas G. Corlett at the age of 87 from complications following a fall, the El Paso County Medical Society lost its oldest actively practicing member.

Born on April 14, 1868, in Buffalo, New York, Dr. Corlett graduated from the University of Buffalo School of Medicine in 1890. Following several years of hospital work in Buffalo, Dr. Corlett moved to Chicago where he practiced for twenty years. In 1913 because of his wife's health he came to Colorado Springs and had been active in general practice there ever since.

Dr. Corlett was always actively interested in hospital staff and Medical Society work and in 1938 served as President of his County Society.

OTTO B. RENSCH

On August 21, 1955, Otto B. Rensch died in Mercy Hospital, Durango, following a prolonged illness.

Born in Ottawa, Illinois, on March 19, 1891, Dr. Rensch was graduated from the University of Illinois Medical School in 1914. He interned at Cook County Hospital in Chicago. In 1919 he moved to Colorado and became associated with National Jewish Hospital, where he remained several years studying pulmonary diseases. In 1923 he opened a private practice in Silverton. He moved to Durango in 1929 following his marriage to Eileen McNamara.

From 1931 to 1935 he served as La Plata County Coroner. He was physician for the Western Colorado Power Company from 1930 and for the D. & R. G. W. Railroad from 1935. For several years he served with the Colorado State Board of Medical Examiners as a member and as President. He was President of Mercy Hospital three times, and served a term as President of the San Juan Basin Medical Society.

He was a member of the Trudeau Society, became a fellow of the American College of Surgeons in 1936, was named Democratic Central Committeeman in 1930 and filled that position until 1946, was a prominent Rotarian, and past District Rotarian Governor.

Survivors are his widow; a son, Jack, and four grandchildren in Ottawa, Illinois; his sister, Mrs. Mary Wells, and a brother, George, both of Ottawa, Illinois.

WILLIAM SENGER

President, Colorado State Medical Society, 1929-30

Dr. William Senger, 81, a founder of the American Board of Surgery and Past President of the Colorado State Medical Society, died at a Pueblo hospital, Monday, September 5. He was a practicing surgeon for more than fifty years before his retirement in 1943.

Dr. Senger became chief surgeon of the Colorado Fuel and Iron Corporation in 1929 and served variously as surgeon for the Colorado & Southern Railroad and as chief of staff at Pueblo's Corwin Hospital. He headed the Pueblo County Medical Society in 1907 and the State Society in 1929-1930.

In addition, he was active in the American Medical Association and a Fellow of the American College of Surgeons. He was chairman of the ACS Colorado division from 1933 to 1937.

Survivors include his wife, Mrs. Mary Knott Senger, and a daughter, Mrs. Frank C. Moore, of

JOHN B. CROUCH

Dr. John B. Crouch, long a leading internist in Colorado Springs, died at the age of 74 on September 18, 1955.

Born in Davenport, Iowa, on December 13, 1880, Dr. Crouch received his medical education at Northwestern University School of Medicine, graduating in 1905. He first came to Colorado as a patient in the Modern Woodmen of America Sanatorium in 1911. The following year he received his state license and became Resident Physician at the Union Printers Home. In 1921 he opened his office for private practice in Colorado Springs, having a special interest in tuberculosis and diseases of the chest. He had been President of the El Paso County Tuberculosis Association and at one time served as Vice President of the National Tuberculosis Association. Dr. Crouch more recently served a term on the Colorado State Board of Medical Examiners.

Immediate survivors are a daughter, Mrs. Rhoda Cramer of Albuqperque, and a son, Dr. Winthrop B. Crouch, of Colorado Springs, also a member of the Colorado State Medical Society.

The diagnosis of active pulmonary tuberculosis is not a simple decision and may be equally troublesome for the family physician and for the medical specialist. This is true when tuberculosis is the only disease to be considered. How much more perplexing is the problem when the disease occurs in the course of other long-term illnesses.—Abraham Gelperin, M.D., Dr. P.H., Leon J. Galinsky, M.D., and Albert P. Iskrant, M.D., Pub. Health Rep., August, 1955.

FILM CATALOG AVAILABLE

Medical societies and individual physicians seeking information on current films available either for professional or lay groups should write to the A.M.A.'s Committee on Medical Motion Pictures for a copy of its latest catalog of medical and health films.

MINUTES
ANNUAL MEETING
HOUSE OF DELEGATES
UTAH STATE MEDICAL ASSOCIATION
September 7, 1955

The 61st Annual Meeting of the House of Delegates of the Utah State Medical Association was called to order at 9:00 a.m. Wednesday, September 7, 1955, by President Charles Ruggeri, Jr.

President Ruggeri: Gentlemen, we will come to order. We will have the Committee on Credentials report.

Dr. Trowbridge: Mr. President, there are a total of 82 delegates. There are 79 present.

The next order of business was the approval of the minutes of the 1954 session. The report of President Ruggeri followed. (Published in the October, 1955, issue, Rocky Mountain Medical Journal.)

Dr. Homer E. Smith moved adoption of the two recommendations in Dr. Ruggeri's report: one, appointment of the Presidents of the various specialty societies as a committee to work in collaboration with the State Association, and, two, that the Building Committee be appointed by the Council to proceed with building plans. Dr. Robinson seconded the motion.

Dr. Cyril Vance: I wish to speak about the first recommendation; that is, that the Presidents of the various specialty groups form a special committee. I represent the Ob.G. Society, not by authorization because the new meetings have not been held since this recommendation came up, but as President-elect for the year 1954-55.

These various specialty groups are accused of setting fees illegally, accused of playing a part in restriction of trade; and I see no need for a special committee of the Presidents of these specialty groups. I don't see why the Council hasn't the authority to call in the Presidents of these societies to meet with them.

Dr. Woolsey: I think we have taken an awful kicking around here this year. I feel that this motion, as made, to make every organization existing within the State of Utah to which doctors belong subservient to and amenable to the laws and rules and regulations of the State Association and the County Associations, is perfectly justified. I can't see any reason why a minority group, whether it be surgeons, obstetricians or gynecologists, ophthalmologists, anesthesiologists, or anything else, should have the power to override the opinion of the parent group.

Dr. Smith's motion carried unanimously.

President Ruggeri: He made two motions. The next one is to delegate authority to the Council to appoint a Building Committee.

Dr. Smith's motion carried unanimously.

Report of the Delegate to the A.M.A.

Dr. George Fister: I congratulate the President of the Utah State Medical Association on such a splendid address. I think an address of that caliber should be read at the General Assembly, and not be confined entirely to the House of Delegates. The President has worked hard this year, and his accomplishments are many.

As Delegate to the A.M.A., I want first of all to thank the Association for the privilege of representing the Utah State Medical Association at the meetings of the A.M.A. And I agree with Dr. Ruggeri; when this year was started, before going to the A.M.A., we had a little Council meeting, at which problems which might be anticipated and over-all policies were discussed and the views of Utah were formulated. Also this year—and I think it is a splendid idea—the Alternate Delegate to the A.M.A. has been authorized to attend the meetings of the A.M.A., which makes Utah doubly active. It is a little difficult for one person to cover all the activities of the A.M.A. House of Delegates. I also want to congratulate again Mr. Bowman, on the splendid work he has done with the State Association and the work he does at the attendance of the A.M.A. meetings. He has been of great assistance to me, and also to the State. I won't read this report, gentlemen, because it has been published.

President Ruggeri thanked Dr. Fister and entertained a motion to accept his report. The report was adopted.

President Ruggeri introduced Mrs. C. O'Neal Rich, Past President of the Utah State Medical Association Women's Auxiliary, and Mrs. Elmo Eddington, current President of the Auxiliary. Mrs. Rich and Mrs. Eddington presented their reports for the year. President Ruggeri also introduced Dr. Samuel P. Newman, President of the Colorado State Medical Society, and Mr. Harvey Sethman, Managing Editor of the Rocky Mountain Medical Journal, both of Denver.

The next order of business was the report of the Secretary.

Dr. Homer E. Smith: I shall not read the printed report of the Secretary, because it is essentially involved in the report of our very capable Executive Secretary, Mr. Harold Bowman. He and his staff have done a very splendid job during this past year, as they do every year. I would like to comment on our Program Committee this year. There is no report here by the Program Committee. The Program Committee this year has taken upon itself to somewhat change the pattern of our State Medical Association meeting. We have brought it down to the Hotel Utah from the campus where it has previously been held. We have, in conjunction with the Cancer Society and the Utah Academy of General Practice, attempted to make a fine meeting, both program-wise, and through the excellent co-operation of the State Auxiliary, we have very good social functions forthcoming. This year we have added a public meeting on automotive crash injuries which has been under the capable direction of Dr. A. M. Okelberry, who is going to chair that meeting at the University of Utah, Kingsbury Hall. A film, "The Search," which was produced by the Cornell Automotive Crash Injury Research Institute, will be shown to the public at our meeting. We are also going to have it shown over television locally.

In conclusion, this is my last year as Secretary. It has been a delightful experience to serve in this office. I should like to express my appreciation of having been able to associate myself with Dr. Ruggeri in the excellent work he has done and the many fine accomplishments on behalf of the Medical Association of the State of Utah for this past year.

President Ruggeri thanked Dr. Smith for the Medical Association of Utah, for the outstanding work he had performed.

up or down?

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Dr. MacFarlane, Treasurer, reported that the financial affairs of the Association have been audited as of the year ending July 31 and found to be well in order. On Page 8 of the Handbook is a condensed statement taken from the audit. He then took up, item by item, the report and the budget, which was adopted by separate lines, with amendments.

President Ruggeri: Are there any further comments on the report of the Treasurer and the budget recommendations?

Dr. Bryner moved to accept the report with the changes made by the motions, seconded by Dr. Robinson, and it was carried unanimously.

The next item of business was the report of the Resolutions Committee.

Dr. Snow: The function of this Committee was rather nebulous. After we met and discussed what we could do, we have come up with a few resolutions covering some of the things that were done during the past year, in an endeavor to provide some continuity with the past administration and the incoming administration.

Whether this Resolutions Committee is a permanent fixture of the State Association or not, I don't know. However, it is my idea that the Resolutions Committee should not be the Committee that hears evidence on all these resolutions, nor should it be the Committee eventually to write the resolutions; but rather to accept the resolutions and make recommendations to the President as to where they should be referred for study.

Actually, I think the State Medical Association and this House of Delegates doesn't function to its best advantage. The State Medical Association should have Committees which should study various problems.

For instance, last year in this meeting, a resolution was presented by one of the members of the House of Delegates. It was discussed at great length, nobody on the floor had enough knowledge to vote on it, and it was finally referred to a committee. And whom was the committee headed by? By the man who presented the resolution. The resolution should be presented to committees that have no fixed ideas about the resolution they are going to hear, and they should get all the information. This was on the relationship of the doctor to the hospital, particularly the general practitioner. Has any evidence been taken from the hospitals themselves by this Committee? Not that we know of.

I think that the Committee which gets resolutions should hear evidence about these resolutions so the Committee can make proper recommendations to this body. Then this body can act intelligently.

The Resolutions Committee this year has drawn up a number of resolutions which have been distributed. I will read the "Resolve" parts of them, and ask you to read the "Whereas" portion as you go along.

The first one is a resolution on "Accreditation of Hospitals by the Joint Commission for Accreditation of Hospitals." For your information, this was one of the key questions that was taken up in sessions of the House of Delegates of the American Medical Association last June in Atlantic City. There was a great deal of discussion as to what the Commission should do, and as to whether it has been high handed in its actions.

Resolution No. 1

WHEREAS, During the past year the Joint Commission for the Accreditation of Hospitals has seen fit to remove the accreditation from all four of the Salt Lake Hospitals for reasons which seem to be arbitrary and high handed; and,

WHEREAS, The Joint Commission on Accreditation has performed similar acts in other parts of the country; and,

WHEREAS, This subject has been brought to the attention of the House of Delegates of the American Medical Association by numerous resolutions presented at the meeting of the House of Delegates in June, 1955, at Atlantic City:

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Utah State Medical Association go on record as urging the special committee which was appointed by the Speaker of the House of Delegates of the American Medical Association in their June, 1955, meeting, to study the whole problem of accreditation of hospitals, so that in the future the Commission will be prevented from using arbitrary and high handed methods in their dealings with hospitals;

THEREFORE, BE IT FURTHER RESOLVED, That the Executive Secretary be instructed to send all information obtainable to this committee appointed by the American Medical Association, regarding the actions taken by the Joint Commission on Accreditation of Hospitals in Salt Lake City in 1954 and 1955.

Dr. Fister moved adoption of the resolution, seconded by Dr. Woolsey, and carried unanimously.

Resolution No. 2

WHEREAS, During the past two decades, many specialist organizations have grown up in the State of Utah; and,

WHEREAS, These specialists' organizations are largely limiting their activities to scientific pursuits, but have, on occasions, seen fit to study and make recommendations as to the economic position of the members of these societies; and,

WHEREAS, These recommendations frequently are at odds with the policies of the Utah State Medical Association:

THEREFORE, BE IT RESOLVED, That the President of the Utah State Medical Association appoint a committee to study the relationships of the various specialist societies in the State of Utah, and their relationships to the Utah State Medical Association, and make a report with recommendations at the meeting of the 1956 House of Delegates.

Dr. Snow moved that the resolution be adopted; seconded by Dr. Woolsey, and carried unanimously.

Resolution No. 3

WHEREAS, The Executive Committee of the Council of the Utah State Medical Association has, during the past year, had several meetings with representatives of organized labor to discuss the various problems which have arisen concerning the care of the laboring man and his dependents as a result of the rapid increase in obtaining of so-called "fringe benefits": and,

WHEREAS, These meetings have had a profound effect upon the relationships between organized labor and the medical profession at large; and,

WHEREAS, There is great need for the continued agreeable relationships between organized labor and the medical profession:

THEREFORE, BE IT RESOLVED, That the President of the Utah State Medical Association, at his discretion, either appoint a committee or use the Executive Committee of the Council of the State Medical Association as has been done heretofore, to continue to meet with representatives of organized labor as the occasions may arise; and,

BE IT FURTHER RESOLVED, That this committee be instructed that the Utah State Medical Association insists on the following basic principles in their relationships with organized labor, fraternal organizations, schools, colleges, federal or state agencies, and any other organization that might desire to purchase medical services:

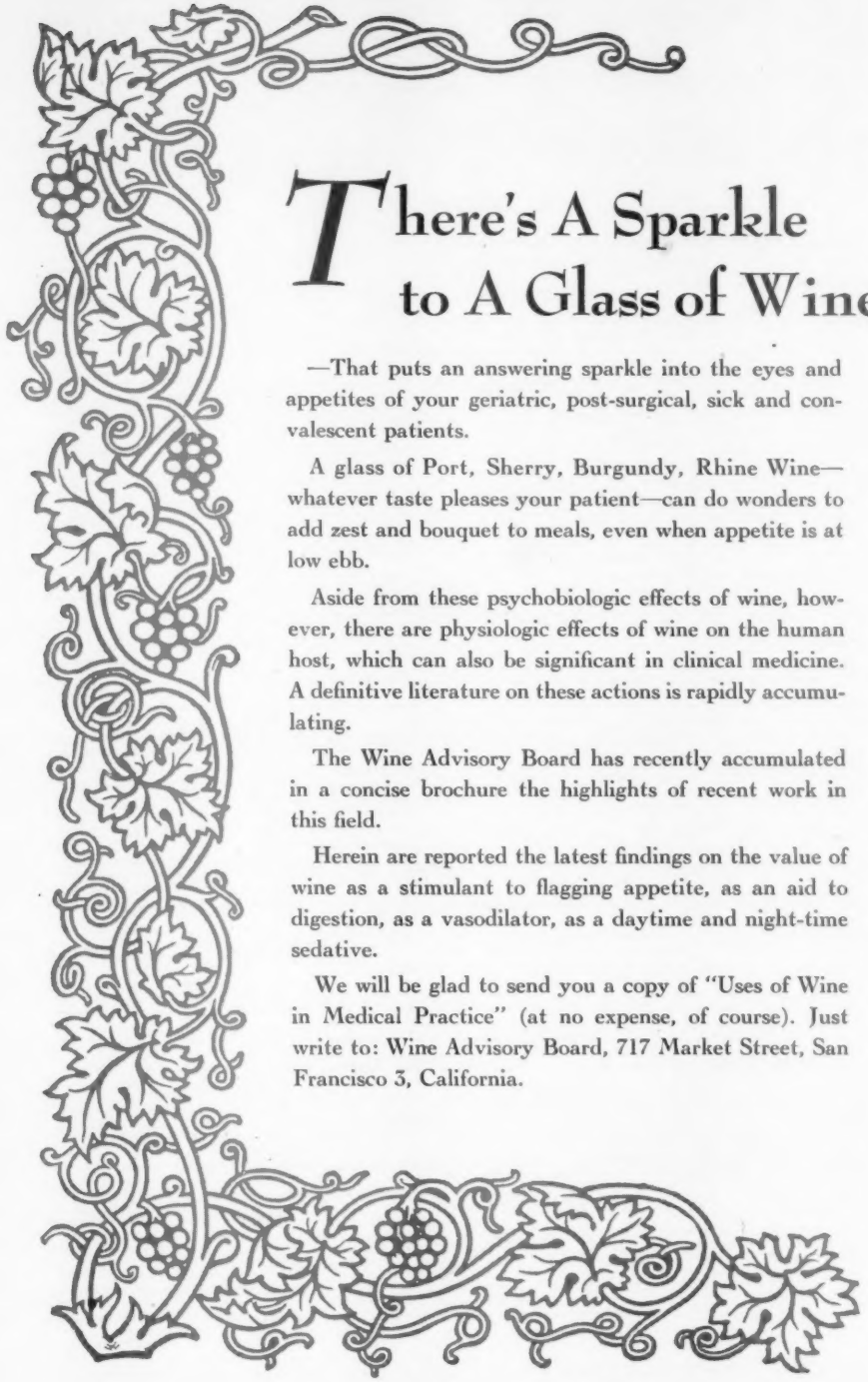
1. Free choice of physician.
2. Usual fee for services rendered.
3. The ethics of medical profession be adhered to, and all patients be treated on an equal basis.

Dr. Snow moved adoption of this resolution; seconded and carried unanimously.

Resolution No. 4

WHEREAS, The population of the State of Utah and the surrounding areas has increased tremendously in recent years; and

(we inserted "surrounding areas" with



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malice aforethought, because the hospitals in this city and state serve not only Utah but Idaho and Nevada and western Colorado.)

WHEREAS, The hospitals in Salt Lake City, which largely service this population, have not kept pace with this increase in population:

THEREFORE, BE IT RESOLVED, That the Utah State Medical Association go on record as urging the hospitals in Salt Lake City to extend their facilities as rapidly as possible.

Dr. Snow moved adoption of the resolution, seconded by Dr. Brooke. Dr. Robinson moved to amend the resolution's last sentence as follows:

"THEREFORE, BE IT RESOLVED, That the Utah State Medical Association go on record as urging more hospital facilities in Salt Lake City as rapidly as possible."

Dr. Snow accepted the amendment. Thereupon a vote was taken and the resolution, as amended, was adopted unanimously.

A Resolution on Social Security

WHEREAS, The Congress of the United States in recent years has rapidly extended the coverage of Social Security; and,

WHEREAS, The House of Delegates of the American Medical Association has gone on record as opposing Social Security for doctors; and,

WHEREAS, There are large numbers of doctors who are not in agreement with the action taken by the House of Delegates of the American Medical Association:

THEREFORE, BE IT RESOLVED, That the Council of the Utah State Medical Association or a committee made up of various members of the Council, be appointed to study the subject of Social Security for the medical profession; and,

FURTHER BE IT RESOLVED, That this Council or Committee of the Council draw up resolutions concerning their findings to be presented at the House of Delegates of the American Medical Association meeting in 1956, concerning the stand of the Utah State Medical Association.

Dr. Snow moved adoption of the resolution; seconded and carried unanimously.

Resolution on Finances of the Association

WHEREAS, The Planning Committee of the Utah State Medical Association, in the report of 1953-54, made certain recommendations concerning a study to be made by the auditors employed by the Utah State Medical Association, to analyze the expenditures made by the Association during the past five years; and,

WHEREAS, This report has not been made, there are numerous demands made upon the Treasury of the Utah State Medical Association which in the opinion of many members of the Association have no direct relationship to the running of the Association; and,

WHEREAS, There are numerous other problems involved in the expenditures of the monies collected through dues to the Utah State Medical Association:

THEREFORE, BE IT RESOLVED, That the President of the Utah State Medical Association appoint a three-man committee, headed by the Treasurer of the Utah State Medical Association as Chairman, to study the financial situation of the Utah State Medical Association, and report at the next meeting of the House of Delegates of the Utah State Medical Association.

Dr. Snow moved adoption of the resolution; seconded by Dr. Hunter, and carried unanimously.

Resolution on Civil Defense

WHEREAS, Our State and Nation is medically unprepared for mass handling of casualties or management of vast hordes of evacuees from populous to sparsely settled regions, especially in the west; and,

WHEREAS, The leaders in our profession and our hospital administrators and medical supply distributors are giving full time diligently to earning a livelihood and are therefore unable to serve without pay as volunteers to hypothetical and often visionary problems without much prospect of successful accomplishment; and,

WHEREAS, The Senate Armed Services Committee recommends that a governmental agency delegate the responsibility for medical preparedness and coordinating professional resources and skill to succeed in mass casualty and evacuee care requiring interstate cooperation; and,

WHEREAS, Forty-five states and territories have legislation providing close relationship in both natural disaster and military or sabotage destruction to utilize the services and facilities of the local relief agencies, the National Guard, the American Red Cross, together with the Civil Defense organization under the Governor in each State:

THEREFORE, BE IT RESOLVED, That the Armed Services Committees of the Senate and House of Representatives be urged by the appropriate committee of the American Medical Association to implement legislation or regulations to assign medical reserve officers to temporary active duty with the State or Federal Civil Defense Administration, for periods of fourteen to ninety days, with pay according to rank;

BE IT FURTHER RESOLVED, That because the doctors from fifty to seventy years of age will be responsible for Civil Defense Service to great masses of evacuees and mass handling of casualties in rural and sparsely settled regions, they also be considered for such active duty to prepare their own communities for skillful medical management in event of disaster.

Dr. Grua moved to table the resolution; seconded by Dr. Olsen, and the motion to table carried unanimously.

Resolution No. 8

To Guide Actions of the Members of the Medical Profession as They Pertain to Professional and Legislative Practices in Hospitals

WHEREAS, It is secured by the Bill of Rights, and by the laws of our State, the right for free men to assembly, to organize, and to legislate in order to maintain, retain, or to secure their basic rights and freedom; and,

WHEREAS, There has been an increasing trend in hospitals to restrict, circumvent, or even to abrogate these basic rights; and,

WHEREAS, Much of this basic trend has been sponsored and fostered by Hospital Administrators, Boards of Trustees of Hospitals, and by the American Hospital Association; and,

WHEREAS, Much of this restrictive legislation is forced upon the medical profession, due to a critical lack of basic governing principles within the medical profession itself; and,

WHEREAS, This deficiency and lack of universal understanding within the profession has resulted in schisms within the profession; and,

WHEREAS, There is great need for the profession to adopt basic guides to assist in future negotiations with Boards of Trustees of Hospitals and Hospital Administrators:

NOW, THEREFORE, BE IT RESOLVED, That the Utah State Medical Association does establish the following principles and rules to assist and guide members of the medical profession in their professional and legislative dealings in hospitals:

1. That it is self-evident that it is the basic right of every M.D. who has qualified for practice in a given state by fulfilling all the requirements by law of that state, to have available to him and his patients, hospital facilities, if such facilities are present, and if such hospital has qualified legally as a general hospital.

2. That it is also self-evident that this basic right should not be denied any physician except when such physician has been adjudged unworthy of this right by the duly constituted authorities of his own hospital staff. In such an event, such member shall have the right of appeal, as provided by the Constitution and By-laws of the Utah State Medical Association.

3. That no member of the Utah State Medical Association shall participate in the formation of any rules or regulations in hospital practices which restrict, circumvent, circumscribe, or otherwise infringe upon this basic right of the doctor to admit to and to care for his patients in such hospital. This does not imply nor in any way suggest immunity of any member from local hospital staff regulations which promote proper care of the patient, but it does imply that no patient shall be taken away from, or otherwise referred for care to another physician except by referral and consent of the admitting physician.

4. That no member of the Utah State Medical Association shall participate in setting up qualifying standards for staff membership or for practice in a hospital which would impose training for which facilities are not reasonably

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available, or which would require training in specialty residencies when the graduate desires training in rotating residencies in order to qualify for general practice.

5. A hospital staff must be self-governing in order to assure freedom to legislate, to elect general officers, to elect heads of departments, and to otherwise set rules and regulations governing the practice of medicine and surgery in the hospital. This should be in cooperation with, and in harmony with the Board of Trustees and the Administrator, but the Staff must be independent in its government.

6. A member of the Utah State Medical Association shall not in any way circumvent or abrogate either the letter or the spirit of self-government.

7. Either the Administrator or (and) and Board of Trustees of any hospital may file in writing with the Council of the Utah State Medical Association, a complaint regarding the improper conduct of any staff member of said hospital. The Council shall appoint a special committee consisting of five members (none of these members shall be on the staff of the hospital in question) which shall hear such complaint and make its recommendations to the Council of the Utah State Medical Association, and such Council, after study, shall make such recommendations to the local staff of said hospital as seems to properly adjudicate the matter, and such recommendations shall be binding upon both the staff and the Board of Trustees.

Dr. Snow moved that this resolution be referred to the Committee on Medical Education and Hospitals of the Utah State Medical Association; seconded by Dr. Vance.

Dr. Robinson: I would just like to know what the prerogatives of the Committee are in studying this resolution, and when it be acted upon, or what the procedure will be after it is referred? Is there any defined procedure?

President Ruggeri: There is a defined procedure on all Committees. They report to the Council with their recommendations, and then the Council has authority to act in the interim between House of Delegates meetings. In view of the fact that Dr. Vance says that Reference Committee No. 3 has taken up this problem and there are other facets to it. I suggest that we recess for lunch and reconvene at 1:30 p.m.

(12:35 p.m.—Noon recess.)

At 1:30 p.m. the House of Delegates reconvened.

President Ruggeri: If you will come to order, we will proceed. With your permission, I would like to put off the subject we were discussing before we adjourned for lunch until a more appropriate time, because there are some other facets of that problem, and I think if we wait and take them all up together we will save time.

We will proceed with the report of the Councilor of Box Elder Medical Society. Is the Councilor here? (No response). We will go on to the report of the Councilor from Cache Valley Medical Society.

Dr. S. M. Budge: During the fall and winter of 1954 the Cache Valley Medical Society carried out the immunization programs for Cache and Rich Counties and also pre-school examinations. So far this year from January the Society was active in the following:

1. Pre-school examinations and immunization in Cache and Rich Counties.

2. Outlined care of the patients at Sunshine Terrace, the home of the aged.

3. Panel discussions open to the public on various subjects during the months of January, February, and March. By the way, we had a very good turnout. We had as many as twelve, fifteen hundred at each meeting.

4. Participated in polio immunization in Cache and Rich Counties.

5. A new constitution and by-laws was drawn up and published for the Cache County Medical Society.

6. Earlier in 1954 blood typing was completed for Cache and Rich Counties and there were about 14,000 typed and tattooed.

President Ruggeri: The next is the report of the Councilor of Carbon County Medical Society.

Dr. Merrill: The report can be found on Page 33 of the Handbook, so you can all read it. There are one or two things about the Carbon County Medical Society. We include not only Carbon County, but Emery County, San Juan, and Grand County, which goes down to Monticello and Blanding, and down to Moab. We thought earlier in the year that perhaps with all you fellows putting your money in uranium that there would be enough doctors flock down in that country that they could form their own society down around Moab and Monticella. But as it turned out, I think more left down there than went in, as far as doctors are concerned. I believe they have two doctors in Moab at the present time, and one in Blanding, and a new doctor just went into Monticello.

Those doctors are quite a ways from our Society, and it is hard for them to get up to our meetings, which we always hold in Price. But we do have the two doctors from Emery County who come over to our Carbon County Medical Society. In Carbon County, we have East Carbon, and the doctors around Price. I think all told, we have 32 members. And, as you will note, we have been very peacable down there this year. We haven't had occasion to call down the Medical Society. We have been handling our own problems the best we could. That doesn't mean that everything is peaceful and quiet down there, but we are getting along and not having any major difficulties.

I have been asked several times what is the situation with the United Mine Workers in Carbon County. They do have a United Mine Workers setup, and some of the doctors are on the panel, and some of the doctors are not on the panel, as far as all of the services are concerned. Some of them are on a paid salary, and some are not, but the State Society knows all about the agreements that are being carried out with this organization.

You know John L. Lewis with his program, which is an enormous program. And when you stop and consider that at the end of June of this year they still had $103,000,000 in reserve, you can understand that it is big business with United Mine Workers, and they do considerable throughout the entire United States, whether the American Medical Association agrees with the United Mine Workers or not. The United Mine Workers spent in the United States last year in the neighborhood of $127,000,000. This is divided up among pensions, salaries to their employees, and their organization. Three per cent is all that went to further running of their business. They pay the bills, and so they designate who shall do the work for them; and I don't think that is any different than any other insurance company or any other contract that we have in the State.

President Ruggeri: Thank you, Dr. Merrill. The report of the Councilor of Central Utah Medical Society. Dr. Malouf, is he here?

Dr. Noyes: I happen to be President of the Society down there. Dr. Malouf was our Councilor from that Society, and when he moved up to Logan, we put Dr. Cluff in. We held four meetings during the spring with the Agricultural Extension Department and had fairly good meetings. We entered into the polio drive as far as it would go.

I don't know of anything special down there,

more than has been reported here, and things are going fine, as far as I am concerned.

President Ruggeri: Thank you. The report of the Southern Utah Medical Society: Dr. Williams. Is anybody here to represent him?

Dr. Edmunds: I am not delegated to report, but the report is on Page 38 of the Handbook.

President Ruggeri: The report of the Councilor of the Uintah Basin Medical Society.

Dr. T. R. Seager: My report is found on Page 38. I haven't anything to add to it, and I will let it stand as it is.

President Ruggeri: Thank you, Sir. The report of the Councilor from the Utah County Medical Society: Dr. Jorgenson.

Dr. Jorgenson: Activities of the Utah County Society have gone along well, except for the accidental death of Dr. Walter T. Hastler. At 79 he was still active in his practice, and had been ice skating the day before the accident.

We hadn't tried to get an anesthesiologist, but we have needed one. But for the sake of brevity, we have already covered that and the rest of the report is there. We hope we can smooth out our trouble, and I am certain our trouble is one that is somewhat shared with the rest of you, that there is a tendency of the hospital administrators to want to regulate, if not completely control, the practice of medicine.

President Ruggeri: Thank you. The report of the Councilor of Weber County Medical Society. Rich Johnston.

Dr. Johnston: I have reported as on Page 39. There is nothing new to add.

The study of contracts was formerly a very potent subject in our County. About the time we studied the railroad contract, all the railroad doctors quit. Now we have got a new set, so we have to start all over. The contracts are new, and they are very much alive, and we are not sure we know many of the answers. But I know nothing to add to this report.

President Ruggeri: Thank you, Dr. Johnston. The report of the Councilor of Salt Lake County Medical Society. Dr. Orme. (No response.) Is Dr. Rasmussen of Box Elder County here? (No response.)

We have a new County Medical Society in our State, the Box Elder County Medical Society. They felt that they ought to have their own society again, which they do have, and I think we can report that to you.

New Business

Dr. King: Mr. President, I have a matter for the Society's consideration. It is a copy of a letter I sent to you on September 2.

"The writer has been selected by the Carbon County Medical Society to serve as one of the delegates at the forthcoming meeting.

"I have read the Handbook for Delegates, and have found the several reports as well worthy of consideration.

"The report by Dr. Merrill of the Carbon County Medical Society is especially well written, but it fails to cover the situation as fully as it might.

"It seems to me Dr. Merrill should have reported that within the last three years, the United Mine Workers of America have brought into Carbon County, ten doctors—all subsidized (just this morning a rumor reached me that two more doctors were to be brought in, and a 12-man clinic established.)

"In this activity, the U.M.W.A. is not alone, but has the very efficient help of Kaiser's Permanente.

"It appears to me, and to the old, established doctors with whom I have talked, that the private practice of medicine and the free choice of physician is approaching an end in the Carbon County area.

"I believe it would be to the best interest of the profession as a whole, that a fact-finding committee be appointed to study this Carbon County situation, and report its findings to the House of Delegates at the next annual meeting, or preferably at an especially called meeting. This Committee to be made up of men from outside the Carbon County area, but from a State and National level."

Dr. King then moved that a Committee be appointed as suggested above, to investigate the situation and report back to the next annual meeting, or at any especially called meeting that may occur in the meantime. A vote was taken, and Dr. King's motion carried unanimously.

Dr. James Z. Davis: Congress recently appropriated about $29,000,000 to get everybody immunized for polio. Your State Board of Health has been given the chore of trying to set this up in our State, and we had two alternatives: One would be to employ physicians and send immunization teams to all parts of the State for this purpose. The State Board of Health was reluctant to do this, felt there might be some alternative, and has come up with this idea (indicating document). When Congress passed this legislation, they made it very definite and unequivocal that there be no "means" test. In other words, you couldn't say, "Mr. Jones, you run along. You can afford to buy this vaccine and give it to your family."

The State Board of Health has asked me to present this resolution. Utah's amount, incidentally, is about $200,000. This is almost a third of an annual budget that they dropped into our laps just for one disease.

Resolution

WHEREAS, The Utah State Department of Health has a polio vaccination program as follows:

The Utah State Department of Health will purchase the polio vaccine available as long as funds permit. This vaccine will be supplied to physicians of the State without charge, to vaccinate children and expectant mothers in the priority age groups as officially determined.

The physicians in each county will receive no more of the vaccine than allowed by the percentage table calculated on the number eligible to receive vaccine free.

Physicians will request vaccine needed from the State Department of Health. The order will be filled promptly. The vaccine will be furnished free to the physician, and, in turn, free to the recipients.

Physicians will make their own charges for services rendered. The vaccine will be made available to all children and expectant mothers in priority groups, regardless of the individuals' ability to pay for the vaccine. Sufficient vaccine to give each individual two injections, two to four weeks apart, will be supplied. No provision has been made in this program for a third injection; however, children should receive a third injection about seven months after the second.

BE IT RESOLVED, That the members of the Utah State Medical Association will:

1. Immunize all eligible individuals who request vaccination without charge for the biological. The priority group begins with the five to nine-year-olds (exclusive of children in the National Foundation for Infantile Paralysis program), and will proceed to other groups as established by the National Advisory Polio Vaccine Committee, and the State Advisory Committee.
2. Charge a fee for services rendered to the individual in accordance with his ability to pay.
3. Carry out the intent of Congress, in making polio vaccine available free, by cooperating with the Utah State Department of Health to see that there is adequate Statewide coverage in providing vaccination to children and expectant mothers in priority groups, regardless of the ability of the individual to pay for the biological.

Dr. Davis moved that this resolution be adopted; seconded and carried unanimously.

Dr. T. E. Robinson presented the following:

Resolution on Accreditation of Hospitals

WHEREAS, The present Joint Commission on Accreditation has been privileged a position in the accreditation of hospitals that is tantamount to the control of medical and surgical practice in hospitals; and,

WHEREAS, By rulings already made or being projected by the Joint Commission on Accreditation of Hospitals, the whole course of the future of American Medicine is being directed and controlled by the Commission, as witness, October Bulletin of the Joint Commission on Accreditation of Hospitals, Paragraph No. 7:

"Time limits for recognition of preceptorships or partial residencies should be set for future dates with the understanding that on and after a certain day (say January, '57) such training will not be recognized for new staff appointments. With countrywide uniform acceptance of completed formal residency training as the best means of specialist training, such training should be the only one recognized on all staff applications for specialist appointments in the not too distant future."

This ruling resulted in the proposal and approval by the Executive Staff of the L.D.S. Hospital in Salt Lake City of the following:

"Beginning in 1957, new applicants for privileges in general surgery and/or the surgical specialties, shall have completed all the necessary formal training requirements in their respective fields (if required by the Joint Commission on Accreditation of Hospitals)."

This was approved by Dr. Babcock, Executive Director of the Joint Commission on Accreditation of Hospitals. This means that no more new general practitioners will be allowed to do any surgery in that hospital after 1957. This same ruling could probably soon apply in medicine and obstetrics, and the general practitioner is out of hospitals entirely. This means that all hospital practice will be done by specialists; that because of this ruling, fewer and fewer men will go into general practice, and finally the whole way of medical life has been changed in America by this seemingly innocuous ruling of the Joint Commission on Accreditation of Hospitals; and,

WHEREAS, This same Commission is also privileged indirectly the control of the lives of many people who carry private health insurance, because such insurance is payable only when medical and surgical services are rendered in accredited hospitals; and,

WHEREAS, This Commission controls the supply of interns and residents in hospitals because the Committee on Medical Education and Hospitals of the American Medical Association depends almost wholly on accreditation of a hospital before placing such hospital on the approved list for intern and resident training; and,

WHEREAS, Said Commission also is privileged the indirect control of the undergraduate nursing program in hospitals because the Nursing Association has as a prerequisite that a hospital to train nurses must be accredited; and,

WHEREAS, The medical membership of the Joint Commission on Accreditation of Hospitals does not represent in equity the whole of the profession, but rather represents a potential control of the majority by the minority; and,

WHEREAS, Two minority groups, (the A. C. S. and the A. C. P.) with at least six members guaranteed have been privileged membership on the Commission out of all proportion to their own membership when compared to the medical membership in the American Medical Association; and,

WHEREAS, With the appointment from the American Medical Association of some specialists out of its six members, it does give absolute and definite control of the Joint Commission on Accreditation by specialists; and,

WHEREAS, The profession as a whole was not privileged the right of voting for the medical representatives on the Joint Commission on Accreditation of Hospitals, nor are all the medical members of the Joint Commission on Accreditation of Hospitals appointees of officers who were duly elected by the profession as a whole; and,

WHEREAS, The Joint Commission on Accreditation of Hospitals has the authority to make its own laws, to enforce its own laws, and to punish for infractions of its own laws, and there is no appeal from its ruling except an appeal to the Joint Commission on Accreditation of Hospitals; and,

WHEREAS, The Joint Commission on Accreditation of Hospitals is not responsible to any "body politic in medicine" as a whole; and,

WHEREAS, The Joint Commission on Accreditation of Hospitals has already exercised privileges granted it to cause many schisms within the profession, and to bring much unwarranted criticism upon the profession (as witness, the disaccrediting of all four hospitals in one city of 175,000, including the hospital staffed by only members of a College of Medicine) and this done upon the recommendations of one inspector, all at the same time, so that there was not a single accredited hospital in that city, all four hospitals had been previously accredited, and measured from mortality and morbidity rates, these hospitals were some of the best in the United States, and,

WHEREAS, The continued investiture of such power and authority in a Commission completely devoid of democratic process will not only continue to result in the thwarting of justice and the prostituting of democracy and its processes, but could well lead to a medical revolution or to socialized medicine:

NOW THEREFORE, BE IT RESOLVED:

1. That the American Medical Association withdraw its membership from the Joint Commission on Accreditation of Hospitals, and that it also withdrew all financial support.

2. That the American Medical Association immediately set up its own accrediting body to standardize medical and surgical practices in hospitals.

3. That needed expenses for the program be raised by the necessary increase in yearly dues to the American Medical Association.

4. That if it be just and desirable, that the American Hospital Association have representation on the accrediting body to be formed by the American Medical Association, that such representation shall not constitute more than 25 per cent of the total membership of the accrediting body, and if the American Hospital Association elects to have this representation, it will pay its equitable share of the costs necessary to sustain the activities and duties of the national accrediting body, but the American Hospital Association membership shall not be privileged a vote in the matters pertaining to standardization of medical and surgical practices in hospitals.

5. That in order to establish local participation " . . . and I think we are all entitled to this . . ." and to more nearly arrive at justice and equity in the accrediting of hospitals, that the national representatives, when inspecting a hospital, be accompanied by a Hospital Accreditation Committee, appointed or elected by the State Medical Association wherein the hospital resides, and that the state body submit its own independent report to the national accrediting body, and this along with the report of the representatives of the national accrediting body will form the sources of information from which the accreditation will be approved or disapproved by the national accrediting agency. There shall be a traveling account and per diem allowance paid by the American Medical Association to members of the State Committee. " . . . and I think they should do that, because that is a big job, and particularly in some states."

6. And be it also resolved that the accrediting agency established by the American Medical Association be restricted in its authority to the setting of standards of performance as they relate to records, tissue removal, mortality and morbidity rates, staff meetings, attendance records, etc.; but such agency shall not have authority to regulate the medical ethics of the staff; such ethics are already prescribed by the American Medical Association and by the State and County Medical Societies. Membership on staffs and qualifications to practice must be determined on merit alone as adjudged by the local staff of the hospital. If evidence of unethical practices are found by the accrediting agency, such evidence shall be referred to the proper source of either the State or County Societies for correction of these practices.

7. Be it further resolved that the composition of the accrediting body of the American Medical Association and the State Committee on Accreditation have an equitable representation from the specialists and non-specialist groups.

AND BE IT FURTHER RESOLVED, That upon approval by the House of Delegates of the Utah State Medical Association that the House of Delegates instructs its Delegate to the American Medical Association to present it to the House of Delegates at the American

Medical Association in June, 1956, and vote for the same.

AND BE IT FURTHER RESOLVED, That a full copy of this resolution be forwarded to the State President and Secretary of each State Medical Association with the request that each State Medical Association approve this or a similar resolution, and instruct its delegate to the American Medical Association to vote for the same.

Dr. Robinson: I would like this resolution studied. I think it is very germane to our problem. And if the House of Delegates doesn't feel that it is in a position to vote on it today, I certainly would like to see it referred to the proper Committee for study; because I just can't feel down in my heart that the Joint Commission on Accreditation will ever function successfully until it is properly constituted, and we get in line with legal and democratic processes.

President Ruggeri: Thank you, Dr. Robinson. We passed a resolution this morning on accreditation of hospitals. The question comes up in my mind whether this resolution that Dr. Robinson just read to us might not be more properly a part of the action we took this morning, and have all this information sent to this Committee that is making a study of the problem.

Dr. Robinson so moved and the motion was seconded.

Dr. Fister: That wouldn't mean this resolution offered by Dr. Robinson was automatically passed by the House?

President Ruggeri: No, it means all information pertinent to this question of accreditation will be sent to this Committee.

A vote was taken and Dr. Robinson's motion carried unanimously.

Contract Problems

Dr. Wallace S. Brooke: Representing the Salt Lake County Medical Society. I am asking at this time for instructions from this body concerning the problem of contracts. As you know, the House turned back the problem of the moral and ethical implications of contracts to the County level. The County Executive Committee, or the President, appointed such a committee in Salt Lake County, and I believe also in other counties, particularly Ogden, to study these contracts. So far, in Salt Lake City, most contracts, as far as we can tell, have been turned in. Dr. Skidmore and his Committee of roughly fifteen representative members of the Socety have looked at these contracts, many of which, however, are not completely specific in all details, many of which are simply verbal contracts.

However, the following findings come out: 1, As far as Salt Lake County goes, there have been no official complaints filed with this Committee; 2, no truly unethical situation applies, as far as this Committee can tell by the contracts.

But it is obvious that the County Societies do not, 1, have the power to discipline if such problems do come up, because for instance, the State Constitution gives that power to the State; and 2, this is not a county problem. If contracts, for instance, in Ogden, were handled differently and disciplined differently than those in Salt Lake County, there would be real cause for alarm.

Therefore, as representing Dr. Skidmore, I am asking the Chair to give to the Counties further instructions on what to do with these contracts.

My personal suggestion would be that a special committee be appointed by the Chair to take the contracts in hand from the County Committees, and to carry on from there, particularly insofar as disciplinary action is concerned. For instance, we have not received complete detailed contracts from any of the hospitals where they have hired many of the ancillary services such as pathology and x-ray. We have no power to go in and force them to give us detailed contracts. These are problems which I believe should be carried on at a State level.

President Ruggeri read from Chapter XIV, Section 1, of the By-Laws:

> That no member of the Utah State Medical Association shall engage in any contract, written or verbal, to furnish the medical services for any group or organization without that contract having been approved by a designated committee of his local medical society and the decision of that committee ratified by his local society by a majority vote, and in the event that it is so approved that this contract be submitted to the Council of the Utah State Medical Association for approval or disapproval, the criteria of their judgment to be the standards laid down by the American Medical Association as to what constitutes an ethical contract.

That is our Constitution. It is open for discussion. This question of contract practice and contracts is one of the most important issues facing us today. I think that this should not involve only contracts with industrial organizations. It involves hospitals; it involves all organizations trying to hire doctors on a salary, some for exploitation and some for other reasons.

The question of hospitals comes up, too. We have a statute in our State that a corporation is not permitted to practice medicine. And yet we find hospitals trying to hire and permit only a certain class of specialists to receive membership on the staff, if they sign a contract to work under a percentage. Before the day is over, I hope we come up with some definite understanding, something we can follow through. Let us meet the issue right just as hard as we can and just as honest as we can, and see that each individual doctor receives his rights.

Dr. S. M. Budge: Eight or ten years ago, we considered that contracts in force over a number of years would be continued. For instance, I have had railroad contracts for more than 30 years. What about those contracts that I have had for 30 years?

President Ruggeri: If you want me to answer, I will answer it very simply. I don't care if you have had it for 50 years; if they are exploiting you, it is wrong. I don't see any reason why a private patient should subsidize corporations. Corporations should pay the same fees for services rendered that private patients pay. If they don't do that, they are exploiting you, and it is time we were waking up and making them foot the bill.

Dr. S. M. Budge: Can we go along and take care of those railroad cases, provided they do that, under the form of a contract?

President Ruggeri: The whole principle of this contract business is simple. It is strictly the principle that you may have a contract with anybody, providing they are not exploiting you. That is the whole basis, that is the reason for trying to review these contracts, that we are going to insist in the Medical Association of Utah, that no doctor is being exploited under that basis. You can have a contract, of course.

Dr. Brooke: I would like to hear what the Ogden group have come up with. Is there a member of their Committee here?

Dr. McQuarrie: I am not on the Committee except as an ex-officio member. The last House of Delegates asked that there be a Committee organized for the investigation and study of contracts. The committee has been active, and at least beginning some good work. I haven't heard of any opposition about the payments obtained under the contracts.

In Ogden, most of the members are very much

in favor of what has been said here today, that corporations should not exploit the doctor. I think it is very foolish of the medical profession to care for patients because they belong to some organization, cheaper than he would care for his own friends or his own private patients. Like Dr. Ruggeri says, actually you are asking your own patients to foot part of this bill, or to subsidize this group. I heard one figure at an American Medical Association meeting about three years ago that the medical profession cheated itself out of literally millions of dollars —I think this particular man hit upon the figure of about $40,000,000, because of this one thing.

In other words, if some company comes to me and says, "Now, I will give you all the business if you will do it for about one-third the ordinary price"— well, you might need the money pretty bad, so you go ahead and do it. So in that way, you actually keep a great number of people from medical practice. I think that we should take a very firm stand on this. A lot of them say, "Well, it isn't anybody else's business," but I think it is our business that we do something to keep an individual from taking practice away from other doctors.

And I don't think it is only the cost; I think that one of the biggest things in the whole thing is that we subject ourselves to lay committees, or superintendents, or organizations, and they interfere deeply with our practice of medicine.

Dr. Davis: In reading the Constitution and By-laws of the State Association, it is rather clear about where such action and such investigation should start. I think there may be some other way that an individual making a contract may be involved. In other words, upon becoming members of our organization, he or she does subscribe to our Constitution and By-laws; and they may have the privilege of either keeping their membership in our organization or forfeiting their free right to make a contract. I think there is a legal point there that might be ruled on.

To bring this to a head, let us go back to our Constitution, and let the local societies continue their investigation and their public scrutiny, or making public the information they get. And that in cases where, in their mind, they feel there is possibly some need for disciplinary action, that they rely upon the State Committee on Industrial Health of the State Association, and they refer those cases to them, so that Wally's opposition to lack of uniformity of penalty generally be gotten away from.

I have been a member of this Association about 16 or 17 years. We have been shadow-boxing with this problem in every House of Delegates. Many of us are reluctant to take action against someone who is doing something we did yesterday.

The Committee of which I am chairman was extremely happy when Kennecott Copper broke up a closed circle medical situation of fifty years' standing. It is believed by many members of this Committee that we could proceed from there to the point where we actually have free choice of physicians, which I believe has been one of the cardinal principles in our ethics from the beginning.

And that, essentially, is another point in our contract practice. Nearly always it gives somebody a monopoly. That monopoly, of course, does not create good to the recipient of the service, nor does it create good for the doctor so involved. I speak from experience.

I move that we put it back as provided in the Constitution and By-laws—I see no recourse in what we are discussing, we have no chance of changing them—and in any questionable cases, that the Committee on Industrial Health of the State Association be given those cases for their recommendation for handling.

President Ruggeri: We don't need a motion that we proceed according to our Constitution and By-laws, and that this work of the County Societies be continued and passed on, according to what I read from Chapter XIV, Section 1 of our Constitution.

Dr. Wm. M. Nebeker: My resolution is going to ask just for the formation of a committee. I have made a few suggestions here that some of you will resent, very definitely, but that is not to be included in the resolution, but it's to be kicked around by the Committee.

"2. Immediate formation of a malpractice committee of ten practicing physicians to study our malpractice insurance. The following points should be considered by this Committee:

"a. Reduction of the amount of insurance carried by a large number of physicians since usually a large policy invites a large demand in malpractice."

"This Committee is not to replace the State Medical Legal Committee but to act more like a 'Supreme Court' in the settlement of malpractice claims."

Here is my resolution:

Resolution

WHEREAS, The medico-legal situation in Utah has reached an emergency situation; and,

WHEREAS, The insurance carriers have become rather arbitrary; and,

WHEREAS, Insurance premiums in malpractice are now reaching prohibitive proportions; and,

WHEREAS, It is now necessary that a complete study with power of action in the field of malpractice has become necessary;

NOW THEREFORE, BE IT RESOLVED, That a Committee for the study and action in malpractice be formed, consisting of the Medical Council, Chairman of the Insurance Committee, Chairman of Professional Relations Committee, Chairman of the State Medical Legal Advisory Committee, and Chairman of the Salt Lake County Medical Legal Advisory Committee.

Dr. Nebeker moved adoption of this resolution; seconded and carried unanimously.

Dr. Paul Clayton moved that in the future, since the State Association retains legal counsel, that the legal counsel be present at these meetings. The motion carried unanimously.

Dr. L. H. Merrill: On Dr. King's letter and suggestion, I would like in the record that that is his own letter and not from the Delegates from Carbon County, or from the Councilor of that area.

Dr. King: May I just add an amendment? In reality that is a minority report of the County Society, but not called as a Society at all; just a few fellows got together and gave me the ideas and asked me to put it in that paper, which I did. As you will recall, all I am asking for is a thorough investigation.

Report of Reference Committee No. 1

Dr. R. M. Muirhead: This Committee had seven reports to consider. You have them all in your Handbook.

Report of the Special Committee on Hospital Staff Regulations. In the first paragraph, we doubted that this was a legal step, to offer this resolution that came up this morning. It seems that it should be brought to the House of Delegates before it was put into this report.

And much of the rest of this report was not as clear to some of us as we thought it ought to be, and we would like to refer it back to the Committee for further elucidation to us. We

move that this be referred back to the Committee for further elucidation.

Reference Committee No. 2

Dr. Grua: Reference Committee No. 2 was assigned eight of the committee reports to review and pass on.

Reference Committee No. 3

Dr. Vance: Reference Committee No. 3 met on August 29. All members were present except Dr. Merrill, who asked to be excused.

The report of the Committee on School Health was examined, in which many deficiencies have been noted in school health programs. Routine health examinations have been condemned in favor of more thorough examinations on private bases. The reason is the lack of completeness and thoroughness of school examinations, and absence of current physician conferences. Recognition is made of help by teachers and school health authorities, particularly in screening. The Reference Committee agrees that these deficiencies exist, and recommends more close liaison between school authorities and local medical societies.

The Reference Committee recommends that the Committee on School Health make more specific recommendations to be worked out between school health committees and local medical societies.

Dr. Snow moved that the Fracture Committee be discontinued, and that the State Society organize a committee on trauma, to include highway accidents, but it be entitled, a Committee on Trauma. Dr. Snow's motion, as amended, carried unanimously.

Dr. Vance: Report of the Committee on Newspaper Health Column. The Reference Committee recommends acceptance of this report as given. They recommend further that the members of the Utah State Medical Association be urged to participate in any public relation activities of their local or State Medical Societies.

Reference Committee No. 4

Dr. Riley G. Clark: Reference Committee No. 4 has reviewed the report of the Blood Bank Committee, Legislative Committee, Insurance Plans Committee, Aid to the Aged, and Constitution and By-laws Committee and recommends that these reports be accepted, and I so move.

Dr. Ruggeri: We ought to have a motion that the reports of the four Reference Committees be accepted as a whole.

Dr. Robinson so moved and the motion carried unanimously.

President Ruggeri: That leaves one more item of business that we put off this morning, this question of hospital physician relationship.

You heard some very disconcerting comments today about some of the hospital practices, some of the attempted hospital practices; and I think they are serious enough to merit serious consideration by this House of Delegates. I don't think we should stand idly by and permit any hospital to do what I have had reports claim they are doing, or trying to do, to some of the members of our organization. I don't think we should stand idly by and permit hospitals to get any further into the practice of medicine.

As I understand hospital functions, it is their business to run hospitals, and their business is to stay out of the practice of medicine; and it makes no difference to me, as I see it—and I believe I understand the English language a little bit—whether it is in the field of anesthesiology, pathology, or any of the other forms of practice.

Now we saw within the last year where the L. D. S. Hospital set up a department whereby they are doing special work on cardiology. No free choice of physician there—no anything. All right, there is pathology, there is radiology, there is anesthesiology, there is cardiology, and next it will be obstetrics and gynecology, and then maybe medicine and surgery, and who knows what.

I would like to make the statement—I might not be able to prove it because nobody has ever given me the facts—that I don't believe any hospital is going to hire any doctor to work for them unless they are going to make a profit out of him, and that means exploitation of the physician.

Why any physician would ever want to work for a hospital or a corporation on a contract that brings in exploitation, I don't understand either. Some of the blame belongs right back on our own shoulders. If we haven't got the manhood and character to stand on our own feet and demand our rights, maybe we don't deserve any better than we get.

But we should not let this problem rest on the shoulders of any one individual that might be picked on piecemeal out here in this hospital, and then in another hospital. We should come out with a very definite stand and let them know where the State Association stands.

And it is time we tell the hospitals to tend to their own knitting, running hospitals, and leave the practice of medicine to medical men. And if they are not getting enough money out of the rooms to run the hospital they had better readjust the fees for rooms and not get it out of the doctors' services. We ought to have the courage and the honesty to come up with something that is going to let all the hospitals in our State know just what we mean in unmistakable language.

Hospital Resolution Amended

At this time I would like to continue the discussion we ceased just before we went to lunch; and I hope before this meeting adjourns we come up with something, some definite form of action, that will be unmistakable as to where we stand and what we mean to do.

Dr. Clayton: The logical thing at this time would be to pass the motion referring the resolution to a committee, but I would like to amend it to this extent: That the Committee report back to a special session of the House of Delegates within 60 days; and, further, that in their deliberations, they have the advice of the State Medical Association legal counsel, so that when they come back with a resolution, it is one that we can vote on and will accomplish something.

It doesn't do any good to pass a resolution that won't hold water in court. I offer that as an amendment to the motion.

Dr. Bryner seconded the motion for amendment and it carried unanimously.

President Ruggeri: Will you read the substitute motion?

(Record read as follows: Dr. Woolsey: Let's make these five on this special committee, together with the regular constitutionally-appointed committee, be the members of a special committee to investigate and report back to this special meeting of the House of Delegates.)

A vote was taken, and Dr. Woolsey's amendment carried unanimously.

A Voice: Let's have the motion read as amended.

(Record read as follows: It was moved that this Resolution be referred to a special committee to be composed of the five members on the

special committee together with the regular constitutionally-appointed committee on Medical Education and Hospitals, the Committee to report back to a special session of the House of Delegates to be called sometime before the first of January when the work of the Committee is completed; and further, that in their deliberations they have the advice of the State Medical Association's legal counsel so that when they come back with a resolution, it is one that we can vote on and will accomplish something.)

President Ruggeri called on Dr. Samuel Newman, President of the Colorado State Medical Society.

Dr. Newman: I thank you for the privilege of sitting through your session—it takes me back home. We have hassles like this all the time.

On the serious side, you have discussed many questions today that involve medicine everywhere. These problems that you talked about are not local at all. We have them in Colorado. Contract practice, hospital procedures, and so forth, are no different here than they are anywhere else.

In Colorado, we have a law which helps us control some of the things the hospitals do as far as the practice of medicine is concerned. I am sure that if we do not do as Benjamin Franklin said, "Hang together," we will "Hang separately." I think Eddie Cantor put it somewhat better. He says, "You know what happens to a banana when it leaves the bunch; it gets skinned." So the pathologist, the anesthesiologist, the obstetrician, the general practitioner, the orthopedic surgeon, whoever he may be, could be the next man who might be on a salary if it is allowed to continue, one after another. So you better hang together.

Hospital accreditation in our state has also been a very annoying problem. I am sure that nationally it is an annoying situation. It is a problem that we have to work out.

After all, it is proper that we control, to some degree, procedures in hospitals, which is for the best interest of the patient.

Labor is going to be a problem in our state as well as here. Dr. Ruggeri made the statement they want free choice of physician. I am sure the average laboring man walking down the street does want free choice of physician. The man who represents him across the table from you, or any other bargaining group, doesn't want free choice of physician other than in a limited sense. They will say, "Sure, you can have free choice of our physicians," but they may only have ten, and there may be a hundred in your community.

President Ruggeri thanked Dr. Newman and called on Mr. Harvey Sethman, Managing Editor of the Rocky Mountain Medical Journal and Executive Secretary of the Colorado State Medical Society.

Mr. Sethman: I appreciate the opportunity you have given me so many years of listening to the proceedings of your House of Delegates. I have never gone away from one of these meetings without having learned something. You would be most interested in hearing from me about the present economic status of our Journal. It is good. We will have added approximately $800 to its reserve fund this year. I can't give you the exact figure because our fiscal year ends August 31, and the C.P.A.'s are now completing the annual audit. As you know, we are aiming for an eventual $5,000 reserve against that rainy day that we can't see, but know sometime will probably come. Advertising income and volume is up 11 per cent over last year. The size of the Journal in number of pages has gone up about that same amount. There were a few months, early in the year, when we were holding the size of the Journal down a little bit because we had a temporary "drouth" in scientific articles, but that drouth is now in the past.

President Ruggeri announced that Dr. Scott Smith has been made President-Elect of the National Association of Anesthesiologists, and then delivered plaques to Past Presidents of the Utah State Medical Association.

The plaques read:

"PRESIDENT'S CERTIFICATE OF HONOR
"UTAH STATE MEDICAL ASSOCIATION

"This certifies that Dr. ..... served as President of the Utah State Medical Association during the year .....

"By his unselfish devotion to his profession he advanced the science of medicine for the benefit of the People."

Election of Officers

The next order of business was the appointment of tellers, and report of the Nominating Committee. Dr. Merrill, Dr. Muirhead, and Dr. Scott Smith were named as tellers.

Dr. Weggeland: The Nominating Committee has nominated the following men for the four positions that come up for this year's consideration:

For President-Elect: Dr. James Z. Davis and Dr. Leslie B. White.

For Honorary President: Dr. John Z. Brown, Sr.

For Secretary: Dr. Don Moore, Dr. Juel E. Trowbridge, and Dr. Byron W. Daines.

Delegate to the A.M.A.: Dr. Geo. M. Fister, Dr. U. R. Bryner, Dr. H. R. Reichman.

A motion that nominations be closed was carried unanimously.

President Rigguri: If you will come to order, I will announce the officers you have elected:

President-Elect, Dr. Davis.
Secretary, Dr. Moore.
Delegate to the A.M.A., Dr. Fister.
Honorary President, Dr. Brown.

Now; my last official act as your President! I want to thank the House of Delegates and the members for their attention and devotion to the Utah Medical Association. It has been a pleasure to work for the Association in the interests of the medical profession and better medical care for our people. I want to say to you, too, that it isn't all pleasure; it was an awful lot of work, it takes a lot of time. Be that as it may, when the time is over and you look back, it is nice to feel that you did accomplish something for the good of all of us. I feel that this Association this year has done just that.

It now becomes my very great privilege and my pleasure to present to you your next President. I have known Dr. Porter for a good many years. He is a man of wide experience. He has been a practitioner of medicine for years; his specialty is Eye, Ear, Nose and Throat.

He served at one time as Dean of the two-year Medical School. He served as District Governor of the Kiwanis Club. He has served in various capacities with his Church. He has served as President-Elect, and probably other offices in the Medical Society up there; there are probably too many for me to remember. He has served on the Council this year, and I have become well acquainted with him.

He is a man of high honor and integrity, and I know the steering of the course of the Medical Association next year is in very capable hands, a man with experience, a man who cannot be intimidated, a man that cannot be pressured.

I am sure if you give him any kind of support at all, that we are going to have an excellent year in 1955-56, during his administration.

It is now my very great privilege to introduce to you your new President, Dr. Porter from Logan. (Members stood and applauded.)

President Porter: After listening to all of the things that have been said here today, and sizing up the responsibilities that go with this office, if there is anybody here who has a bid for it, I will be glad to receive it. Charley has just been pouring it on all day . . . what is coming to me in the coming year . . . and I have pretty well known it because I have gone along for six years on the Council and know some of the problems.

(Dr. Porter's address was published in the October issue of this Journal.)

The first official act is to present to Dr. Ruggeri, as Past President of the State Medical Association for the year 1954-55, the much coveted Utah State Medical Association Certificate.

The next item of business is the selection of a meeting place for the convention in 1956. Where shall we meet?

Dr. Robinson moved that Salt Lake City be the next meeting place, and the motion carried unanimously.

At 5:25 p.m., Wednesday, September 7, 1955, the 61st Annual Meeting of the House of Delegates of the Utah State Medical Association adjourned.

New Mexico

Obituaries

WILLIAM CLARE PORTER

William Clare Porter, M.D., Medical Director and Superintendent of the Los Lunas (sic) Hospital and Training School, Los Lunas, New Mexico, died September 3, 1955.

Dr. Porter was born July 28, 1868, in Binghamton, New York, and was graduated from the New York University School of Medicine in 1907.

He entered the Army Medical Corps in 1918 and retired a Colonel in 1948. He became Superintendent o. the Los Lunas Hospital immediately upon retirement.

Dr. Porter was a member of the American Board of Psychiatry and Neurology, the American Psychiatric Association, Four Counties Medical Society, New Mexico State Medical Society and the American Medical Association.

WERNER A. ONSTINE

Werner A. Onstine, M.D., pioneer Taos physician, died September 7, 1955, of a heart attack.

Dr. Onstine was born in 1871 and was graduated from Ohio Medical University in 1896.

He came to Taos, New Mexico, in 1909, where he practiced until 1913, when he moved to Los Angeles. After returning to Taos in 1927 he practiced until his untimely death. Always free with his time and energy, he held clinics each week in the small mountain villages of Questa and Penasco.

Dr. Onstine was honored by the House of Delegates of the New Mexico Medical Society in 1952 for having completed fifty years of practice of medicine. He was elected to Emeritus Membership in 1953 by the House of Delegates. He was a member of the Taos County Medical Society, New Mexico Medical Society and the American Medical Association.

Wyoming

PHYSICIANS FISH

Here are the results of the final report period of the Pfizer 1955 Wyoming and Montana Physicians' Trout Fishing Tournament. Dr. N. E. Morad of Casper, Wyoming, caught a 37-inch Mackinaw to lead Division Number 2 which includes trout caught on spinners, lures and live bait in a river, stream or creek and all lake trout.

In Division Number 1 which includes trout caught on a fly (only) in a stream, river or creek, Dr. W. W. Horsley of Lovell placed third with a 21¾-inch Rainbow, and Dr. H. V. Adams of Sheridan, Wyoming, placed fourth with a 20½-inch Rainbow. Dr. F. D. Sidell of Butte Montana, was first in this division with a 23¼-inch catch.

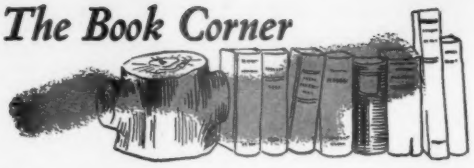
A.M.A. PUBLISHES BOOKLET ON RELATIONS BETWEEN DOCTORS AND HOSPITALS

Just off the presses is a new pamphlet on the relationship of physicians and hospitals published by the A.M.A.'s Council on Medical Service. Entitled, "Relation of Physicians and Hospitals," this sixteen-page booklet contains: (1) "Guides for Conduct of Physicians in Relationships With Institutions" (adopted by the House of Delegates in December, 1951), and (2) "Report of the Joint Committee on Hospital-Physician Relationships of the Boards of Trustees of the American Medical Association and the American Hospital Association" (adopted by the House of Delegates in June, 1953).

Since the House of Delegates adopted the position that the 1953 report should be considered a supplement to the 1951 report, both statements constitute official A.M.A. policy on this subject and are reprinted in this edition. Medical societies, hospital staffs and individual physicians may secure copies from the Council.

Enormous numbers of adult human beings carry tubercle bacilli in a semi-dormant state and hold their infection in check under normal circumstances. However, non-specific physiological disorders can disturb the equilibrium between bacilli and host tissues and convert the latent tuberculous infection into overt tuberculosis.—Rene J. Dubos, Ph.D., J.A.M.A., April 23, 1955.

The Book Corner



New Books Received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.

Feeling No Pain: By Bill O'Malley. Published by Prentice-Hall, Inc., New York, 1955. Pages unnumbered. Price: $1.90.

The Management Of Oral Disease—A Treatise on the Recognition, Identification and Treatment of Diseases of the Oral Regions: By Joseph L. Bernier, D.D.S., M.S., F.D.S., R.C.S. (Eng.). With 1,001 text illustrations and five color plates. Published by The C. V. Mosby Company, St. Louis, 1955. 825 pages. Price: $15.00.

Applied Medical Bibliography For Students: By William Dosite Postell, Medical Librarian and Professor of Medical Bibliography, Louisiana State University School of Medicine, New Orleans, Louisiana. Published by Charles C. Thomas, Springfield, Ill., 1955. 142 pages. Price: $4.50.

Henry Ford Hospital International Symposium on Cardiovascular Surgery, Studies in Physiology, Diagnosis and Techniques: Proceedings of the Symposium Held at Henry Ford Hospital, Detroit, Michigan, March, 1955. Edited by Conrad R. Lam, M.D., Surgeon-in-Charge, Division of Thoracic Surgery, Henry Ford Hospital. Published by W. B. Saunders Company, Philadelphia, 1955. 543 pages, illustrated. Price: $12.75.

Cardiac Diagnosis—A Physiologic Approach: By Robert F. Rushmer, M.D., Associate Professor of Physiology and Biophysics, University of Washington Medical School. Published by W. B. Saunders Company, 1955. 447 pages, illustrated. Price: $11.50.

Basic Surgical Skills—A Manual With Appropriate Exercises: By Robert Tauber, M.D., F.A.C.S., Assistant Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania. Published by W. B. Saunders Co., Philadelphia, 1955. 75 pages, illus. Price: $3.75.

Cancer Cells: By Edmund Vincent Cowdry, Director, Wernse Cancer Research Laboratory, Washington University, St. Louis. Published by W. B. Saunders, Philadelphia, 1955. Illustrated. 677 pages. Price: $16.00.

Office Procedures: By Paul Williams, M.D. Published by W. B. Saunders, Philadelphia, 1955. 412 pages, illustrated. Price: $12.50.

Textbook of Endocrinology: Edited by Robert H. Williams, M.D., Executive Officer and Professor of Medicine, University of Washington Medical School, Seattle. Second edition. Published by W. B. Saunders, Philadelphia, 1955. 776 pages, illustrated. Price: $13.00.

Classification For Medical Literature: By Eileen R. Cunningham, Librarian and Professor of Medical Library Science, Vanderbilt University School of Medicine; with the collaboration of Eleanor G. Steinke, Assistant Librarian, Vanderbilt University School of Medicine. 4th ed., rev. and enl. Published at Nashville, by the Vanderbilt University Press, 1955. 164 pages. Price: $2.75.

Why Patients See Doctors: Results of the Washington Sickness Survey, a statewide study of patients seen by doctors in private practice. By Seymour Standish, Jr., Washington State Health Council; Blair M. Bennett, University of Washington Medical School; Kathleen White, University of Washington Medical School, and L. E. Powers, M.D., American University of Beirut, Lebanon. Published by the University of Washington Press, Seattle, 1955. 94 pages. Price: $2.50.

Book Reviews

Diseases of the Nervous System, Described for Practitioners and Students: By F. M. R. Walshe, M.D., D.SC., F.R.S., Fellow of the Royal College of Physicians of London; Fellow of University College, London; Consulting Physician to University College Hospital, and to the National Hospital of Nervous Diseases, Queen Square. 8th ed. 357 p., illus. and diagrs. Baltimore: Williams & Wilkins Co., 1955. Price: $7.00.

The first edition of this textbook was published in 1940. The author's stated objective, in the first edition, was to provide a practical guide for the student and the general practitioner. This purpose was prosecuted by means of selection, emphasis, and omission of certain subjects.

Using simple terms, the author sought to attract and to offer guidance to the student and the general practitioner with neurologic interests. Redundant and complex terminology, eponymous signs and syndromes, and other words of tyranny, were reduced to a minimum. By simplifying neurology, Dr. Walshe encourages students and practitioners not to accept too easily, defeat or evasion, in a diagnostic problem. The author believes that instruction in simple words supports a confident, methodical approach to diagnostic difficulty, particularly in neurology.

The eighth or current edition is published with the same purposes as the first. Timely revision has been added. This edition consists of 357 pages. The table of contents lists thirty chapters, exclusive of an index. There are fifty-eight illustrations, most of which are diagramatic drawings. There are few photographs; none in color.

The author emphasized that disease should be considered in terms of time as well as space. Changes in disease also occur as medical advance takes place. Thus the first chapter stresses those factors of time such as duration, era, and age, in symptom production. The influence of sex and heredity in the panorama of disease is recognized. The author discusses etiology as an interplay of various forces, not as a singular result of a micro-organism, a trauma, the organism, or of some defective component of the human mechanism. Although the concept of cause is broadened, etiology is reduced to a simple common denominator of multiple factors of causation. Illness is a vital reaction of the organism as a whole. This occurs as a form of behavior, developing in response to adversity. Anatomic, physiologic and psychologic characteristics as factors are considered. Environmental factors such as injury, heat, cold, chemical agents, nutrition, infections and physical agents are described. Although psychological mechanisms are mentioned, it is pointed out that the time has not come for a final assessment of any primary psychologic factor in the production of an organic disease of the nervous system.

Localizing signs aiding in diagnosis are treated anatomically. Disease of the motor neuron is classified under four main categories: pyramidal, extra-pyramidal, cerebellar and the lower motor neuron. Disease of one unit of the motor neuron may or may not be confined to that unit.

The pituitary and hypothalmus are considered as a complex. Anatomic connections are mentioned as well as physiologic interrelationships. Cognizance is given to the fact that lesions in this area may produce serious effects elsewhere. These effects are generalized on and not detailed.

The reactions of various anatomic elements of the nervous system are described in terms of pathologic change. Demyelination is referred to as an abnormality of the myelin sheaths while the axis cylinders remain intact. A second type of white matter change is that of Wallerian degeneration in which fragmentation of the axis cylinder follows demyelination.

The reactions of the glial cell in inflammation, degeneration, and vascular abnormality is simply described. Attention is directed to the nature of the glial cell reactions: regeneration and multiplication. This differentiates the reaction of the glial cell from that of the nerve ganglion cell. The latter reacts to stress by degeneration and necrosis; under no circumstances can these cells undergo regeneration.

Unfortunately, the author fails to confirm or deny a relationship between ganglionic-glial benign cell change and neoplastic proliferation of those cells.

The subject of malignancy is dealt with as sub-heading under space occupying lesions within the skull, along with hematoma, abscess, and granuloma. Relationship to cancer elsewhere in the body is not mentioned. The subject of malignancy of the brain and spinal cord is dealt with in approximately the same number of pages as syphilis of the nervous system. This seems strange, as neoplasm is a most important problem in neurology today, while syphilis is now a minor problem.

The reviewer believes that the author successfully accomplishes his stated purpose in the publication of this book.

GEORGE W. HOLT, M.D.

Antibiotics and Antibiotic Therapy: By Allen E. Hussar, M.D., and Howard L. Holly, M.D. This is the first clinical manual on the properties, potentialities, and limitations of all the antibiotics in clinical practice. A well-organized and comprehensive primer on the subject, sorely needed by the medical student, and practitioner, to guide him through the maze of antibiotics to prevent their incorrect and indiscriminate use. Published by The MacMillan Company, November, 1954. Price: $6.00.

This is a very attractive book which is more easily read than some of the other recent books on antibiotic therapy. The book is divided fundamentally into three sections dealing with general principles of antibotic therapy, pharmacology of individual antibiotics and considerations of the "drug of choice" in a variety of clinical conditions.

The book is written at a clinical level, rather than a highly technical level and this makes it more valuable to the person practicing clinical medicine. In addition to being interesting reading in a rapidly advancing field of medicine, it is also a convenient and up-to-date reference manual for refreshing one's memory as to the "drug of choice" in the many specific infections discussed.

Bibliographies are generally quite recent and certainly complete enough for the person practicing clinical medicine. The book is recommended for any clinician who wishes to have a recent reference text in the field of antibiotic therapy.

W. GRAYBURN DAVIS, M.D.

Physicians' Office Attendants Manual: By Henry B. Gotten, M.D., Associate Professor of Medicine, University of Tennessee, and Douglas H. Sprunt, M.D., Professor of Pathology, University of Tennessee, Memphis, Tennessee. This Manual is in two sections: Section for Office Work and Section for Laboratory Work. Published by Charles C. Thomas, Springfield, Illinois. c1955, 93 p., illus. Price: $3.75.

As indicated in the preface, the chief purpose of this Manual is to guide the novice, rather than

the experienced medical secretary and technologist. Because of the present shortage of registered medical technologists, the University of Memphis has offered an eleven-week course to high school graduates, training them in the simpler procedures with which a physician needs assistance both in the office and laboratory. The Physicians' Office Attendants Manual, created for the purpose of simplifying this course, presents basic and general information, obviously slanted toward the needs of assistants lacking the extensive training and education of registered technologists and medical secretaries. For the beginner in these fields, the Manual gives invaluable guidance, not only by its compact presentation of correct procedure, but also by the fine illustrations which so ably amplify the information.

GEORGE H. CURFMAN, JR., M.D.

"Should the Patient Know the Truth?" Numerous contributors. Samuel Standard, M.D., and Helmuth Nathan, M.D., Editors.

This book constitutes the opinion of twenty-five people, of whom twelve are physicians prominent in medical, surgical and psychiatric fields; seven are registered nurses from both Protestant and Catholic institutions; two are attorneys; one is an educator; three are clergymen representing Catholic, Protestant and Jewish points of view. Each writer has been given one chapter to express his ideas in answer to the question.

All the contributors, with the exception of one, have adopted a middle-of-the-road philosophy in recognizing that a categorical approach is not possible, since both circumstances and patients vary so widely. Nearly every writer has been able to cite instances in which one approach would have been detrimental to the welfare of the patient, concluding, therefore, that the physician must weigh the question each time he is confronted with it, and make the answer help the patient, not hurt him. One writer, Dr. Wangensteen, has expressed his opinion categorically by stating that the answer should always be "yes." Dr. Wangensteen indicated that only in this way can the physician have the complete cooperation of the patient in dealing with the proper form of therapy. He feels that, "To fail to tell patients they have cancer is as archaic and out-moded as Victorianism." The Catholic clergymen and the Catholic nurses agree with a middle-of-the-road philosophy depending upon the circumstances, except that in the event of a patient's impending death he must always know, if possible that he is going to die in order that specific and important functions of the church in redeeming the patient's soul before he passes on to another world, may be carried out.

In general it may be said that, although the book does not intend to answer the question for all time to come, it does present a broad cross section opinion of the leaders in the field of medicine, religion and the law. These opinions are interesting even though the reader is still left to make up his own mind concerning the problem.

BERNARD T. DANIELS, M.D.

Handbook of Pediatrics: By Henry K. Silver, M.D., Associate Professor of Pediatrics, Yale University School of Medicine, New Haven, Connecticut; C. Henry Kempe, M.D., Assistant Professor of Pediatrics, University of California School of Medicine, San Francisco, California; and Henry B. Bruyn, M.D., Assistant Professor of Pediatrics and Medicine, University of California School of Medicine, San Francisco, California, Assistant Clinical Professor of Pediatrics, Stanford University Medical School, San Francisco, California. Los Altos, California, Lange Medical Publications, 1955. 548 pages. Price: $3.00.

Truly an outline of pediatric procedure, diagnosis and treatment. This volume has a very unique thumb index from its table of contents that lends itself to quick reference.

The text is, of course, concise but very much up to date with a nice balance between discussion of diagnosis and treatment. The volume represents a valuable addititon to a pediatric library.

WARD L. CHADWICK, M.D.

ELECTIONS

Your State's Executive Office appreciates being notified of the results of your component society elections. Not only can State Secretaries thus keep their records up to date, but they are better able to route inquiries to the appropriate component society officer.

Constant alertness to reversion to endemic and epidemic conditions is essential, and some situations, especially tuberculosis, require determined and drastic attention, but generally speaking, the public health programs are drifting away from the early ages of high infant and maternal mortality and the communicable diseases toward adult health, chronic disease, cancer, heart, diabetes, nutrition, mental health, and accident prevention. Most of these latter conditions demand sound and knowing participation on the part of the individual and his family. The mass approach alone will not be productive.—Henry F. Vaughan, Dr. P.H., Am. J. Pub. Health, March, 1955.

WANTADS

ESTABLISHED, attractive, completely furnished, completely equipped, general practice office on Littleton Blvd., Littleton, Colorado, in rapidly growing area. Unlimited parking. Available October 1, 1955. Write to Box 337, Tripler Army Hospital, Honolulu, T.H.

WANTED AT ONCE: Well-trained general practitioner between ages of 30-40, speaking Spanish and English fluently to join 4-man group in Tucson; Spanish-American very acceptable. Must be particularly interested in obstetrics, preferably with one or two years' residency in same. Salary first year commensurate with qualifications, $800.00 minimum a month for first six months, $900.00 a month for second six months, then partnership. Send picture, medical background, racial extraction, marital status, three letters of recommendation, with first letter. Should have license in state having basic science law. Write Old Pueblo Medical Group, Dr. Fred C. Gregg, 41 East Jackson, Tucson, Arizona.

WANTED—A technician for laboratory; prefer a registered technician. All types of blood chemistry—B.M.R., E.K.G., and Bacteriology. Salary open; available immediately. Samuel Nelson, M.D., 212 Colo. Bldg., Pueblo, Colo.

FOR RENT—715 South University in Bonnie Brae Shopping Center. 1,600 square feet divided into five rooms. Plenty of parking. Rent $210 per month. Call DE. 3-1642.

WILL RENT office space in Republic Building to Internist. X-ray, Ekg. and Laboratory Facilities. Call KE. 4-3434.

OFF TO BOSTON!

Quaint old Boston, with its crooked streets and historic landmarks familiar to every American schoolboy, has much to offer physicians and their wives planning to attend the A.M.A.'s ninth annual Clinical Meeting November 29 to December 2. An outstanding scientific program covering all phases of medicine—including lectures, round-table discussions, color television and motion picture films—has been lined up for A.M.A. visitors. In the Scientific Exhibit, leading authorities from all over the country will be on hand continuously throughout the four-day meeting to answer questions and discuss problems with doctors. The Technical Exhibition will feature the latest developments in equipment, books and pharmaceuticals.

This year's meeting promises to be one of the largest Clinical Sessions on record. Both the Scientific and Technical Exhibits will be held in the Mechanics Building, and the House of Delegates will meet at the Statler Hotel. Arrangements are being completed to make this session a worthwhile postgraduate medical education "course." Plan now to attend!

With the tuberculosis death rate continuing its gratifying sharp decline, the tuberculin reaction is becoming increasingly important in differential diagnosis.—James E. Perkins, M.D., Journal-Lancet, April, 1955

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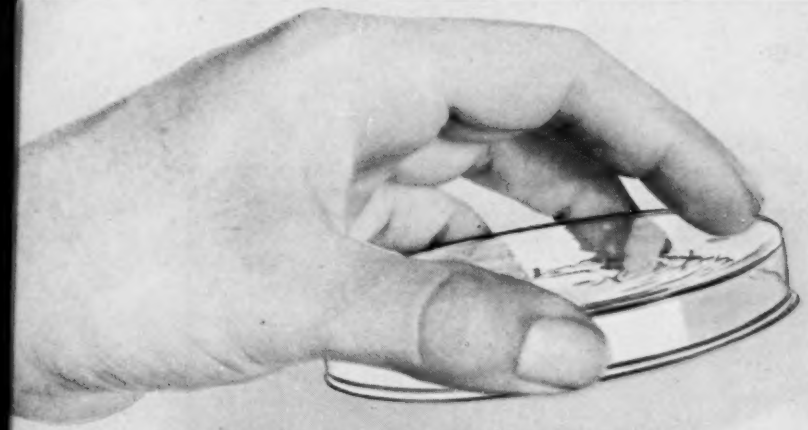
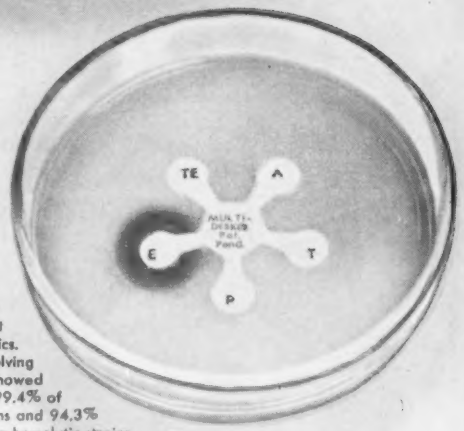
Index to Advertisers





DESTROYS ENTEROCOCCI

This blood agar plate shows a strain of *beta* hemolytic enterococcus. Note extreme sensitivity of this organism to ERYTHROCIN—yet it easily resists the other antibiotics. Additional data: A study[1] involving 202 enterococcic strains showed sensitivity to erythromycin in 99.4% of *alpha* hemolytic strains and 94.3% of *beta* hemolytic strains.

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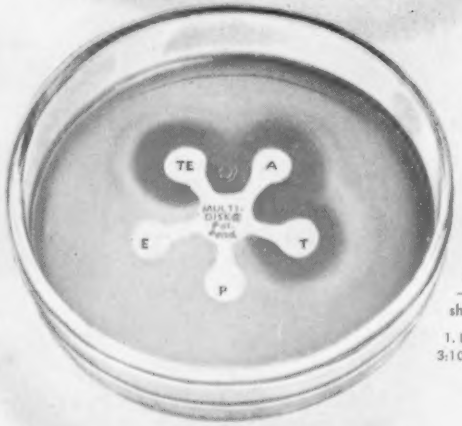

SPARES

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This sensitivity test shows ERYTHROCIN and the same antibiotics against a typical intestinal strain of E. coli. Note that ERYTHROCIN and penicillin do not affect this gram-negative organism —although the other antibiotics show marked inhibitory action.

1. Eisenberg, et al., Antib. & Chemo., 3:1026-1028, Oct., 1953.

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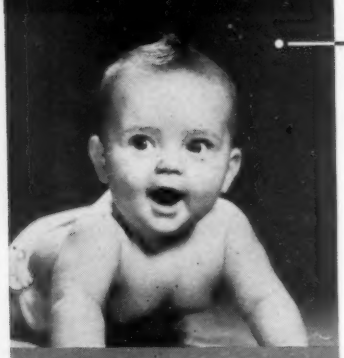

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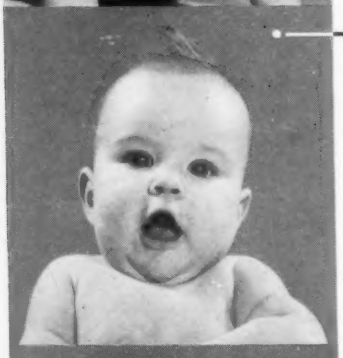

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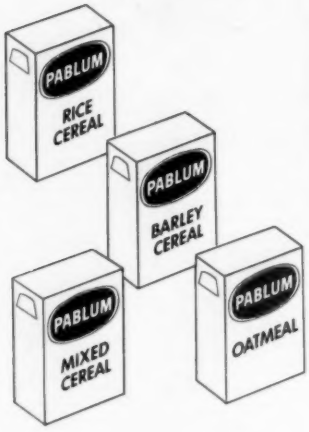
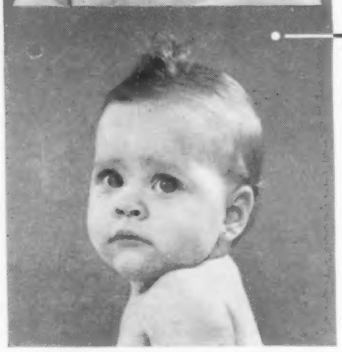
Pablum Oatmeal
Pablum Mixed Cereal





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